

# IMPORTANT NAME CHANGE ANNOUNCEMENT

## Larotid<sup>TM</sup> (amoxicillin) is the new name for Larocin

Since its introduction in March of 1974, Larocin has been prescribed more than a million times by physicians in the United States. In several of these instances, written prescriptions for Larocin have been confused with Lanoxin, Burroughs Wellcome Company's brand of digoxin. Although the reported incidence of such confusion has been extremely low, Roche Laboratories has changed the name of its product to LAROTID (amoxicillin). We hope you will agree that this action is in the best interest of the patient and of everyone concerned.

Before prescribing, please consult complete product information, a summary of which follows:

**Indications:** Infections due to susceptible strains of the following gram-negative organisms: *H. influenzae*, *E. coli*, *P. mirabilis* and *N. gonorrhoeae*; and gram-positive organisms: streptococci (including *Streptococcus faecalis*), *D. pneumoniae* and non-penicillinase-producing staphylococci. Therapy may be instituted prior to obtaining results from bacteriological and susceptibility studies to determine causative organisms and susceptibility to amoxicillin.

**Contraindications:** In individuals with history of allergic reaction to penicillins.

**WARNINGS:** SERIOUS AND OCCASIONALLY FATAL HYPERSENSITIVITY (ANAPHYLACTOID) REACTIONS REPORTED IN PATIENTS ON PENICILLIN THERAPY. ALTHOUGH MORE FREQUENT FOLLOWING PARENTERAL THERAPY, ANAPHYLAXIS HAS OCCURRED IN PATIENTS ON ORAL PENICILLINS. MORE LIKELY IN INDIVIDUALS WITH HISTORY OF SENSITIVITY TO MULTIPLE ALLERGENS. BEFORE THERAPY, INQUIRE CONCERNING PREVIOUS HYPERSENSITIVITY REACTIONS TO PENICILLINS, CEPHALOSPORINS OR OTHER ALLERGENS. IF ALLERGIC REACTION OCCURS, INSTITUTE APPROPRIATE THERAPY AND CONSIDER DISCONTINUANCE OF AMOXICILLIN. SERIOUS ANAPHYLACTOID REACTIONS REQUIRE IMMEDIATE EMERGENCY TREATMENT WITH EPINEPHRINE, ADMINISTER OXYGEN, INTRAVENOUS STEROIDS AND AIRWAY MANAGEMENT, INCLUDING INTUBATION, AS INDICATED. Usage in Pregnancy: Safety in pregnancy not

established.

**Precautions:** As with any potent drug, assess renal, hepatic and hematopoietic function periodically during prolonged therapy. Keep in mind possibility of superinfections with mycotic or bacterial pathogens; if they occur, discontinue drug and/or institute appropriate therapy.

**Adverse Reactions:** As with other penicillins, untoward reactions will likely be essentially limited to sensitivity phenomena and more likely occur in individuals previously demonstrating penicillin hypersensitivity and those with history of allergy, asthma, hay fever or urticaria. Adverse reactions reported as associated with use of penicillins: Gastrointestinal: Nausea, vomiting, diarrhea. Hypersensitivity Reactions: Erythematous maculopapular rashes, urticaria. NOTE: Urticaria, other skin rashes and serum sickness-like reactions may be controlled with antihistamines and, if necessary, systemic corticosteroids. Discontinue amoxicillin unless condition is believed to be life-threatening and amenable only to amoxicillin therapy. Liver: Moderate rise in SGOT noted, but significance unknown. Hematologic and Lymphatic Systems: Anemia, thrombocytopenia, thrombocytopenic purpura, eosinophilia, leukopenia, agranulocytosis. All are usually reversible on discontinuation of therapy and believed to be hypersensitivity phenomena.

**Dosage:** Ear, nose, throat, genitourinary tract, skin and soft tissue infections—Adults: 250 mg every 8 hours. Children: 20 mg/kg/day in divided doses every 8 hours; under 8 kg, 0.5 ml of Pediatric Drops every 8 hours; 8-8 kg, 1 ml of Pediatric Drops every 8 hours. Lower respiratory tract infections and se-

vere infections or those caused by less susceptible organisms—Adults: 500 mg every 8 hours. Children: 40 mg/kg/day in divided doses every 8 hours; under 6 kg, 1 ml of Pediatric Drops every 8 hours; 6-8 kg, 2 ml of Pediatric Drops every 8 hours. Gonorrhea (acute uncomplicated anogenital and urethral infections)—Males and females: 3 grams as a single oral dose. NOTE: Children weighing more than 8 kg should receive appropriate dose of oral suspension 125 mg or 250 mg/5 ml. Children weighing 20 kg or more should be dosed according to adult recommendations.

**Note:** In gonorrhea with suspected lesion of syphilis, perform dark-field examinations before amoxicillin therapy and monthly serological tests for at least four months. In chronic urinary tract infections, frequent bacteriological and clinical appraisals are necessary. Smaller than recommended doses should not be used. In stubborn infections, several weeks' therapy may be required. Except for gonorrhea, continue treatment for a minimum of 48-72 hours after patient is asymptomatic or bacterial eradication is evidenced. Treat hemolytic streptococcal infections for at least 10 days to prevent acute rheumatic fever or glomerulonephritis.

**Supplied:** Amoxicillin as the trihydrate: Capsules, 250 mg and 500 mg; oral suspension, 125 mg/5 ml and 250 mg/5 ml; pediatric drops, 50 mg/ml.



Roche Laboratories  
Division of Hoffmann-La Roche Inc.  
Nutley, New Jersey 07110

ABC

Med Trib 39

# Medical Tribune

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world news of medicine and its practice—fast, accurate, complete

and Medical News

Wednesday, November 5, 1975

## From Planned Parenthood:

### New Guidelines Set For Contraception In Women Over 40

BY FRANCIS GOODNIGHT  
Medical Tribune Staff

NEW YORK—What advice about contraception methods should be given to women over 40 in the wake of recent reports from Britain that use of oral contraceptives by older women is linked to an increased risk of myocardial infarction?

The guidelines definitely include making sure that such patients receive full information about the risk-benefit ratio of the agents, says Dr. Louise B. Tyrer, vice president for medical affairs of the Planned Parenthood Federation of America.

Dr. Tyrer emphasized during an interview with MEDICAL TRIBUNE that the new reports constitute the first documented proof of association between the "pill" and heart attacks.

An aftermath, she noted, has been the announcement by the Food and Drug Administration that it plans to revise labeling for oral agents to reflect the recommendations of its obstetrics and gynecology advisory committee that patients over 40 "be made thoroughly aware of the increased risk and be urged to utilize other forms of contraception."

Findings from the British studies indicate that the estimated incidence of nonfatal myocardial infarction in women aged 40 to 44 is 9.9 per 100,000 nonusers of oral contraceptives compared to 56.9 per 100,000 users in the

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## making rounds at press time

**A LITTLE INSURANCE**—14 Atlanta restaurants and two hotels overcharge for cigarettes and split profit between heart and cancer research. The idea, begun by late owner of the Coach and Six who quit smoking after an M.I., is continued by his widow, Mrs. Beverly Soloff. She told MT that in 1 yr. 1 machine took in an extra \$3800. "People who smoke are the most frightened of all and their reaction is incredibly good. They feel less guilty for smoking and feel like they're buying a little insurance."

## Transposed Arteries: First Total Correction

By NATHAN HORWITZ  
Medical Tribune Staff

DETROIT—The first successful total correction of transposed great arteries was reported here by a Brazilian surgical team.

Overcoming technical problems that have frustrated heart surgeons for more than two decades, the team was able to transfer the position of the coronary

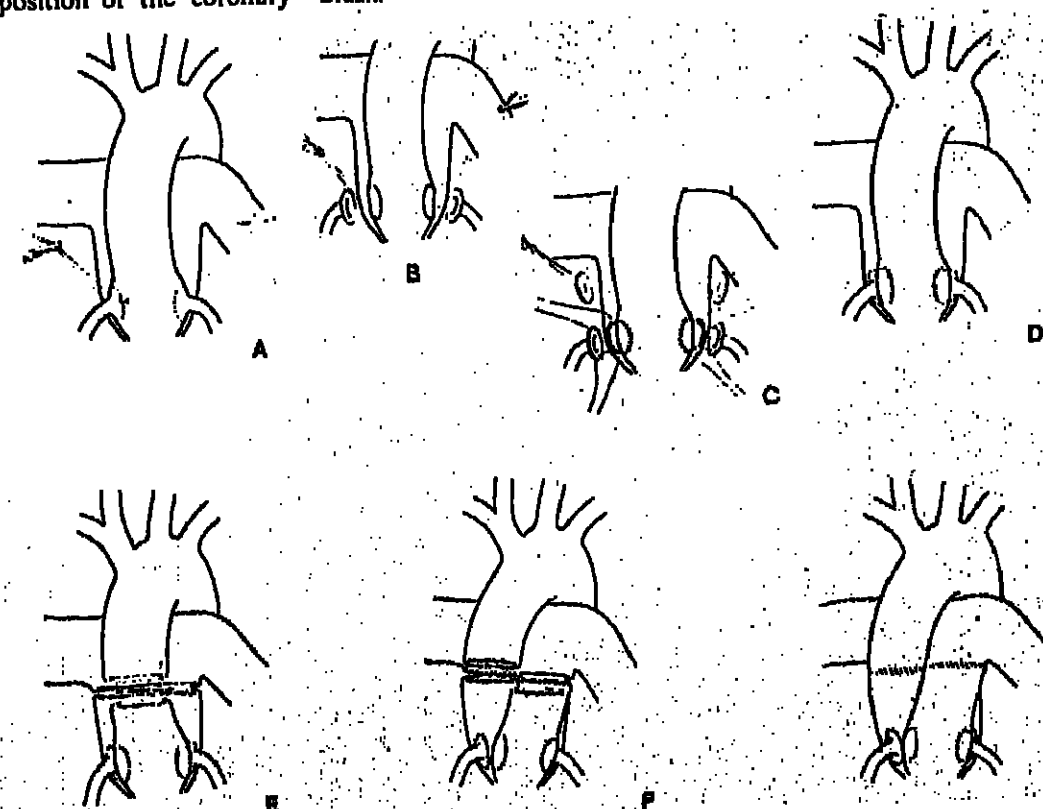
arteries in retransposed great vessels and achieve normal blood flow conduits in a 40-day-old infant with a large ventricular septal defect, Dr. A. D. Jatene told the 2nd International Symposium on Cardiac Surgery at the Henry Ford Hospital.

Dr. Jatene is Professor of Surgery at the Cardiologic Institute in Sao Paulo, Brazil.

The achievement was described as a "great technical triumph" by Dr. John W. Kirklin, Professor and Chairman of the Department of Surgery, University of Alabama. He added that Dr. Jatene's procedure offers "a very exciting" surgical approach, especially in patients with a large VSD.

In describing the new procedure, Dr. Jatene said:

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Schematic presentation of the new procedure for total anastomotic correction of transposed great vessels in patients with VSD. Figure (A) shows ascending aorta, presently anterior, pulmonary trunk, presently posterior, and the proximal portion of the coronary arteries. Two sutures in the anterior wall of the pulmonary artery show where the coronaries will be sutured. The coronaries are excised (B), along with pieces of the aortic wall, and the openings are closed with a patch. At (C) and (D), corresponding pieces are resected from the pulmonary artery and the coronaries are implanted in the new sites. Ascending aorta and pulmonary trunk are resected (E), with differences in diameter between the vessels corrected by two sutures in the distal and proximal stumps of pulmonary artery. Distal end of pulmonary artery is sutured to proximal end of anterior artery, now without coronaries.

## Major Victory Seen In Capitation Grant Policy Reversal

Medical Tribune Report

WASHINGTON—The Ford administration has reversed its policy, inherited from the previous administration, to end capitation grants to medical and dental schools and has unveiled a new proposal that is expected to move the long-stalemate health manpower legislation several steps closer to enactment.

The policy change is viewed by observers as a major victory by new H.E.W. Secretary F. David Mathews, Ph.D., and Dr. Theodore Cooper, Assistant Secretary for Health, over the Office of Management and Budget.

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## High Cataract Rate Found in Child Asthmatics on Steroids

Medical Tribune Report

DENVER—A high incidence of cataract formation in asthmatic children who regularly take corticosteroids was reported here by a team of physicians from Fitzsimons Army Medical Center and the National Asthma Center.

The study, presented at the 28th Annual Symposium on Pulmonary Diseases here, revealed cataract formation in 10.8 per cent of 92 long standing, severe, steroid-dependent asthmatics.

Although past animal studies have been unable to prove a definite cause and effect relationship between steroid use and cataract formation, Dr. Harry S. Spaulding Jr., chief of the pediatric outpatient service at Fitzsimons, said physicians should definitely be alerted

to the association of chronic steroid use in child asthmatics with a change in lens pathology.

"Overall, the children in our study ranged from 11 to 15 years of age with an average five-year history of steroid dependency. Slitlamp examination by two independent ophthalmologists revealed definite cataract formation in 10 children, with an additional 21 patients showing some change in lens pathology."

"Obviously some of these children wouldn't be alive or couldn't function normally without steroids, despite the advances made in chemotherapeutic agents. However, we think physicians should be made aware of our findings."

Dr. Spaulding told MEDICAL TRIBUNE.

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## New Drug Combination Held Effective Against All Bacteria

Medical Tribune Report

WASHINGTON, D.C.—Development of a new antibacterial combination drug which has proven effective against every bacterial species tested so far, including *Pseudomonas aeruginosa*, was reported here by investigators from the Merck Sharp & Dohme Research Laboratories at a conference sponsored by the American Society for Microbiology.

While the drug has not as yet been studied in man, extensive laboratory and animal tests suggest it may be a potential alternative agent in the treatment of bacterial strains that have acquired a resistance to other antibiotics, the scientists said.

### Guarded Reaction

Initial reaction to the report was guarded. Reflecting the opinion of many, Dr. Merrill Snyder, Professor of Medicine in Clinical Microbiology at the University of Maryland School of Medicine in Baltimore, said, "While I commend the investigators on their work, the results are far from applicable to man. The concepts that have been presented are certainly intriguing but whether this will have some practical application remains to be seen."

MK641/MK642, as the drug is currently known, works by inhibiting bacterial cell wall biosynthesis, explained Frederick M. Kahan, discoverer of the

antibacterial combination.

Although bacterial cell wall biosynthesis is also the target of attack of several classes of widely-used antibiotics, including the penicillins and cephalosporins, the new agent is chemically unrelated. It is a fixed ratio combination of 2-deutero-3-fluoro-D-alanine (DFA), a new substance synthesized by Merck scientists, and a derivative of cycloserine (PCS), a 20-year-old antibiotic with limited therapeutic applications.

When combined, the two elements work synergistically to prevent bacteria from synthesizing D-alanine, an indispensable constituent of the cell wall of every type of bacteria, the research team explained.

Development of MK641/MK642 derived from observations that bacteria produce D-alanine through enzymatic conversion of L-alanine and that while L-alanine plays a key role in human metabolism, D-alanine does not. Therefore, the team theorized, an agent which prevented production of only D-alanine would eliminate bacteria in an infected individual without interfering with normal body functioning.

Biologic analyses of DFA show that it prevents bacteria from synthesizing the necessary D-alanine. However, DFA in concentrations several times higher than the minimum inhibitory

### Hospital Visitor



Japan's Empress Nagako (right rear) looks on as patients at Chicago's Wyler Children's Hospital prepare for surgery.

concentration has the paradoxical ability to restore bacteria to normal growth. In a phenomenon called "self-reversal," DFA is used by bacteria in place of the missing D-alanine, Mr. Kahan told the meeting.

The addition of PCS, he continued, successfully prevents bacteria from using DFA and thereby ensures DFA's

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## Antidotes Listed On Toxic Products Termed Outdated

Medical Tribune Report

DENVER—Many common household products that can be injurious if swallowed or inhaled still carry outdated and possibly harmful information about antidotes on their package labels, a clinical toxicologist warned here.

Dr. Barry H. Rumack, director of the Rocky Mountain Poison Center in Denver General Hospital, cited numerous examples of such faulty antidotal information, including the directives given on containers of *Drano*, *Parson's Ammonia*, *Easy-Off Oven Cleaner*, and *Johnson Wax Company's Big Wally*.

"The primary problem is that managements of poisons have been improved and upgraded over the years, and many of the companies haven't changed their labels—or at least that portion of their labels—in many years," Dr. Rumack told a conference on critical care held at Swedish Memorial Hospital.

To provide up-to-date information for physicians on potential poisons and their treatment, Dr. Rumack and his colleagues have developed a compendium on more than 100,000 products and compounds. Called "Poisonindex," the poison information system is now used at some 125 hospitals and emergency rooms.

In the case of *Drano*, Dr. Rumack explained that the antidote directive correctly warns against induction of vomiting if the substance has been swallowed. However, the label also advises giving vinegar or a citrus fruit juice. Since *Drano* is an alkali, the natural acids in these liquids "may cause an increase in the burning of the mouth or esophagus."

### 'Absolutely Wrong'

The final instruction is to follow the juice with butter or a cooking oil which he calls "absolutely wrong, since it will inhibit the physician's ability to determine the extent of injury and what further treatment is necessary."

Another instance of an outdated antidote directive, according to Dr. Rumack, is the caution found on the labels of most petroleum distillates, oils, and other hydrocarbons, to avoid induction of vomiting.

He said that most major poison centers now follow the policy of inducing emesis if the patient has ingested a possibly toxic amount of hydrocarbon, is breathing normally, has no central nervous system depression, and has a good gag reflex.

If only a very minor amount of the chemical has been ingested, then catharsis alone is probably adequate. But at the other extreme, if the patient already shows CNS or respiratory depression, then intubation should be performed followed by gastric lavage.

The fact that parents usually turn first to the antidotal information on labels when a child ingests or inhales a toxic substance is of particular concern to Dr. Rumack. He recommends that anyone facing a poison emergency contact a poison information center before giving any antidote.

## Individualized Therapy Urged in Breast Ca

Medical Tribune Report

HOUSTON—"The availability of many different therapies for a given condition reflects the inadequacy of any single modality," said Dr. Charles K. Tashima, Associate Professor of Medicine, The University of Texas Health Science Center at Houston. "Such is the case for breast cancer."

Improvement in treatment can be made by better selecting patients to receive various treatment options: surgery, radiotherapy, endocrine manipulation and chemo-immunotherapy, he told a seminar on the medical management of malignancy sponsored by the M.D. Anderson Tumor Institute.

Dr. Tashima indicated that he favored the Halsted radical mastectomy "when the disease is sufficiently limited in extent so that cure is possible." Less extensive surgical procedures, combined with radiotherapy, represent another alternative. The axilla is not usually irradiated if dissection is adequate, though with significant risk of recurrent disease in the chest wall, the wall will be irradiated, he said.

### Chemo-Immunotherapy

Dr. Tashima emphasized that treatment should be modified to fit an individual patient, with emphasis in initial presentation on surgery and radiotherapy. Chemo-immunotherapy currently used in his department consists of FAC-BCG (5-FU, Adriamycin and Cytosin plus BCG) which produces a response in 75 per cent of patients and median remission of 16 months. Adriamycin is the best single drug in use, Dr. Tashima stated.

He does not recommend prophylactic castration in breast cancer patients nor does he suggest taking women off birth control pills. "Patients with functioning ovaries are probably not affected by small additions of hormones, so that birth control pills are usually not contraindicated in menstruating women," he said. However, he does recom-

mend cessation of hormones for replacement therapy for menopause. "Even small doses of estrogens can aggravate breast cancer once it has developed clinically," he said.

However, patients with receptor-containing tumors may benefit from endocrine therapy. Fifty per cent of primary tumors and a small percent of metastatic lesions are estrogen-receptor positive.

Dr. Tashima uses the team approach in determining appropriate therapy. Radiotherapist, oncologist, and surgeon together determine the treatment plan. The surgeon's role has somewhat changed since axillary dissection may now be more important as a staging procedure than as a method of cure. "The recent adjuvant studies utilize the presence of axillary metastases as an indication for chemotherapy," he said. Such staging should not necessarily be classified by usual methods, which relate to the surgeon's ability to benefit a patient, but should be based on clinical evidence showing primary, regional or metastatic carcinoma.

The doctor also takes exception to the concept of cure. "Cure in cancer is not common, but we are able to do more than palliate our cancer patients. We can now often render a patient clinically free of disease, but usually only for a variable period of time."

Dr. Tashima proposes a new concept, N.E.D. (no evidence of disease), to formalize this philosophy. If a patient were N.E.D., there would be no symptoms referable to cancer, no physical findings of cancer, and no x-ray, scan or laboratory findings indicating the presence of cancer. To formalize such a classification, the physician would consider extent of disease prior to a specific treatment, treatment type, and duration since treatment.

Such a concept would help to determine the recurrence possibility for various groups. He feels it is urgent, since adjuvant chemotherapy significantly affects recurrence rates and survival.

He also feels a method of categorizing patients according to number of sites involved, amount of tumor, and tumor growth rate would further help

to select patients for appropriate therapy, including those patients for whom no treatment is appropriate.

### Significant Risk

"In spite of the aggressive approach we have adopted, all the modalities of therapy carry a significant risk and the side effects of treatment are considerable," Dr. Tashima said. For the patient with a small primary and negative axillary nodes, no radiotherapy or adjuvant chemoimmunotherapy is offered, since a radical mastectomy provides a 10-year survival for 80 per cent of patients. He also mentioned the occasional patients with asymptomatic metastatic disease, who have lived with their disease for a number of years. "They appear to have an adequate defense to the tumor and treatment may even be deleterious for these patients."

Though a patient with both primary and metastatic disease may undergo a simple mastectomy, radiotherapy, and chemotherapy, Dr. Tashima again emphasized his belief in the radical procedure, if the choice is simple vs. radical. "There's lots of discussion about things that probably won't make a difference in overall survival. But until more data are in, I would go with the radical," he said.

## Lung Disease Mortality Dropped in Fuel Shortage

Medical Tribune Report

BERKELEY, CALIF.—The mortality rate from cardiovascular and chronic lung disease decreased substantially in the San Francisco Bay area during last year's nationwide fuel shortage but returned to normal levels when it ended, concluded a study by Dr. Stephen Brown of the U.C.—Berkeley School of Public Health.

When gasoline sales fell nearly 10 per cent around San Francisco, the death rate from such chronic lung ailments as bronchitis, asthma, and emphysema dropped 33 per cent in San Francisco and 38 per cent in less-urbanized Alameda County. Heart disease deaths also dropped, by 17 and 11 per cent in the respective areas, he said.

## Appetite Control Mechanism Studied



Photo By Susan Pogony

Studies in monkeys of the brain's appetite control centers and the mechanism of satiety are conducted by Dr. Paul R. McHugh at the University of Oregon Health Sciences Center, and have shown that satiety in animals receiving food directly into stomach is influenced more by calories than nature of food.

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CLINICAL NEWS NOTE: "Physicians have a right to refuse to prescribe the [oral contraceptive] agents if in their best judgment—after reviewing the history, the physical, and the lab tests—they feel the patient's risk is too high. They have to be able to practice according to the dictates of their conscience combined with their best medical judgment." (Dr. Louise B. Tyrer, vice president for medical affairs, Planned Parenthood Federation of America. See page 1.)

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**WARNINGS**  
Use with caution in severe renal disease. In patients with renal disease, thiazides may precipitate azotemia. Cumulative effects of the drug may develop in patients with impaired renal function. Thiazides should be used with caution in patients with impaired hepatic function or progressive liver disease, since minor alterations of fluid and electrolyte imbalance may precipitate hepatic coma. Thiazides may be additive or potentiative of the action of other antihypertensive drugs. Potentiation occurs with ganglionic or peripheral adrenergic blocking drugs.

**Usage in Pregnancy**  
Usage of thiazides in women of childbearing age requires that the potential benefits of the drug be weighed against its possible hazards to the fetus. These hazards include fetal or neonatal jaundice, thrombocytopenia, and possibly other adverse reactions which have occurred in the adult.

**Nursing Mothers**  
Thiazides cross the placental barrier and appear in cord blood and breast milk.

**PRECAUTIONS**  
Periodic determination of serum electrolytes to detect possible electrolyte imbalance should be performed at appropriate intervals. Observe patients for clinical signs of fluid or electrolyte imbalance (hypotension, hypochloremic alkalosis, and hypokalemia). Serum and urine electrolyte determinations are particularly important when the patient is vomiting excessively or receiving parenteral fluids. Medication such as digitalis may also influence serum electrolytes. Warning signs are dryness of mouth, thirst, weakness, lethargy, muscular fatigue, hypotension, oliguria, tachycardia, and gastrointestinal disturbances such as nausea or vomiting.

Hypokalemia may develop with thiazides as with any other potent diuretic, especially during brisk diuresis, when severe cirrhosis is present, or during concomitant administration of steroids or ACTH. Interference with adequate oral intake of electrolytes will also contribute to hypokalemia. Digitalis therapy may exaggerate metabolic effects of hypokalemia, especially with reference to myocardial activity.

Any chloride deficit is generally mild and usually does not require specific treatment except under extraordinary circumstances (as in liver disease or renal disease). Dilutional hyponatremia may occur in edematous patients in hot weather; appropriate therapy is water restriction rather than administration of salt, except in rare instances when the hy-

ponatremia is life-threatening. In actual salt depletion, appropriate replacement is the therapy of choice.

Transient elevations in plasma calcium may occur in patients receiving thiazides, particularly in those with hyperparathyroidism. Pathological changes in the parathyroid gland have been reported in a few patients on prolonged thiazide therapy.

Hypocalcemia may occur or frank gout may be precipitated in certain patients. Insulin requirement in diabetic patients may be increased, decreased, or unchanged. Latent diabetes may become manifest during thiazide administration. Thiazide drugs may increase the response to tubocurarine. The antihypertensive effect of the drug may be enhanced in the post-sympathectomy patient. Thiazides may decrease arterial response to norepinephrine. This is not sufficient to preclude effectiveness of the pressor agent for therapeutic use.

If nitrogen retention indicates onset of progressive renal impairment, consider withholding or discontinuing diuretic therapy. Thiazides may decrease serum PBI levels without signs of thyroid disturbance.

**ADVERSE REACTIONS**  
Gastrointestinal—nausea, gastric irritation, nausea, vomiting, cramping, diarrhea, constipation, hiccups (intravenous administration), pancreatitis, Central Nervous System—dizziness, vertigo, paraesthesia, headache, xanthopsia, dermatologic—urticaria, necrotizing angitis, Steven-Johnson syndrome, and other hypersensitivity reactions.

**Hematologic**—leukopenia, granulocytosis, neutropenia, aplastic anemia, Cardiovascular—orthostatic hypotension may occur and may be potentiated by alcohol, barbiturates, or narcotics. Other—hyperglycemia, glycosuria, hyperuricemia, muscle spasm, weakness, restlessness. When adverse reactions are moderate or severe, reduce dosage or withdraw therapy.

**DOSE**  
Individualize dosage by titrating for maximum therapeutic response at the lowest possible dose. **Hypertension—Initial**—Usual dose 75 mg daily. **Maintenance**—After a week dosage may be adjusted downward to as little as 25 mg or upward to as much as 100 mg daily. Continued therapy. When necessary, other antihypertensives may be added gradually and with caution because of the potentiating effect of this drug. Dosages of single-acting blockers should be halved.

**Edema—Initial**—25 to 50 mg daily for several days. **Maintenance**—25 to 100 mg daily or intermittent. Refractory patients may require up to 200 mg daily. **SUPPLIED**  
Tablets, 50 mg (yellow, scored) bottles of 30, 60, 100, 1000, 5000, and Accu-pak blister units of 30, 60, 100, 1000, and 5000.  
Tablets, 25 mg (pink, scored) bottles of 30, 60, 100, and 5000.

Consult complete literature before prescribing.  
CIBA Pharmaceutical Company, Division of CIBA-GEIGY Corporation, Summit, New Jersey 07901.

C I B

Wednesday, November 5, 1975

MEDICAL TRIBUNE

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## Implanted 'Umbrella' Filter Prevents Recurrent Emboli

Medical Tribune World Service

AMSTERDAM, NETHERLANDS — Apart from general prophylaxis, one of the safest and most effective ways to prevent recurrent pulmonary embolism is to implant an "umbrella" filter in the infra-renal vena cava, a German surgical team reported at the 9th European Federation Congress of the International College of Surgeons here.

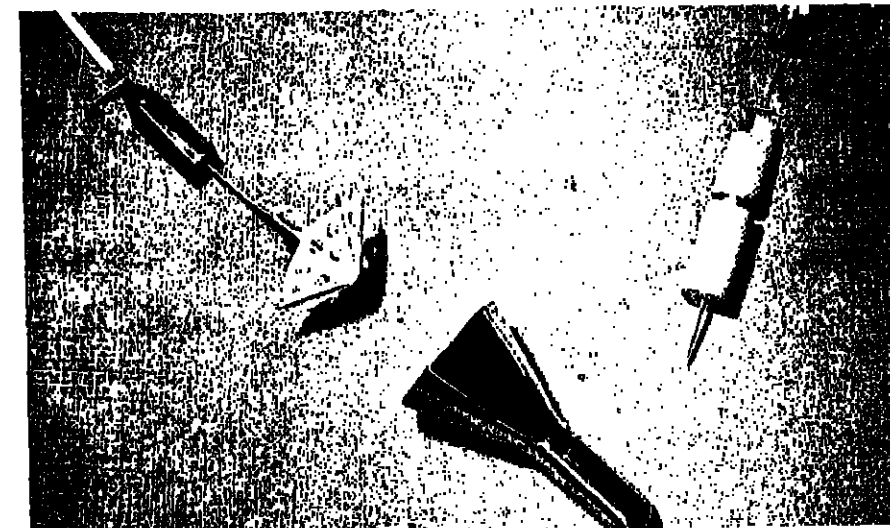
Since the overwhelming majority of pulmonary artery emboli reach the lung from the lower extremity through the inferior v. cava, the method of choice is to interrupt the pathway between the confluence of the pelvic veins and the entry of the renal veins,

Dr. Volkur Schlosser, head of the department of cardiovascular surgery, Freiburg University Clinic, stated.

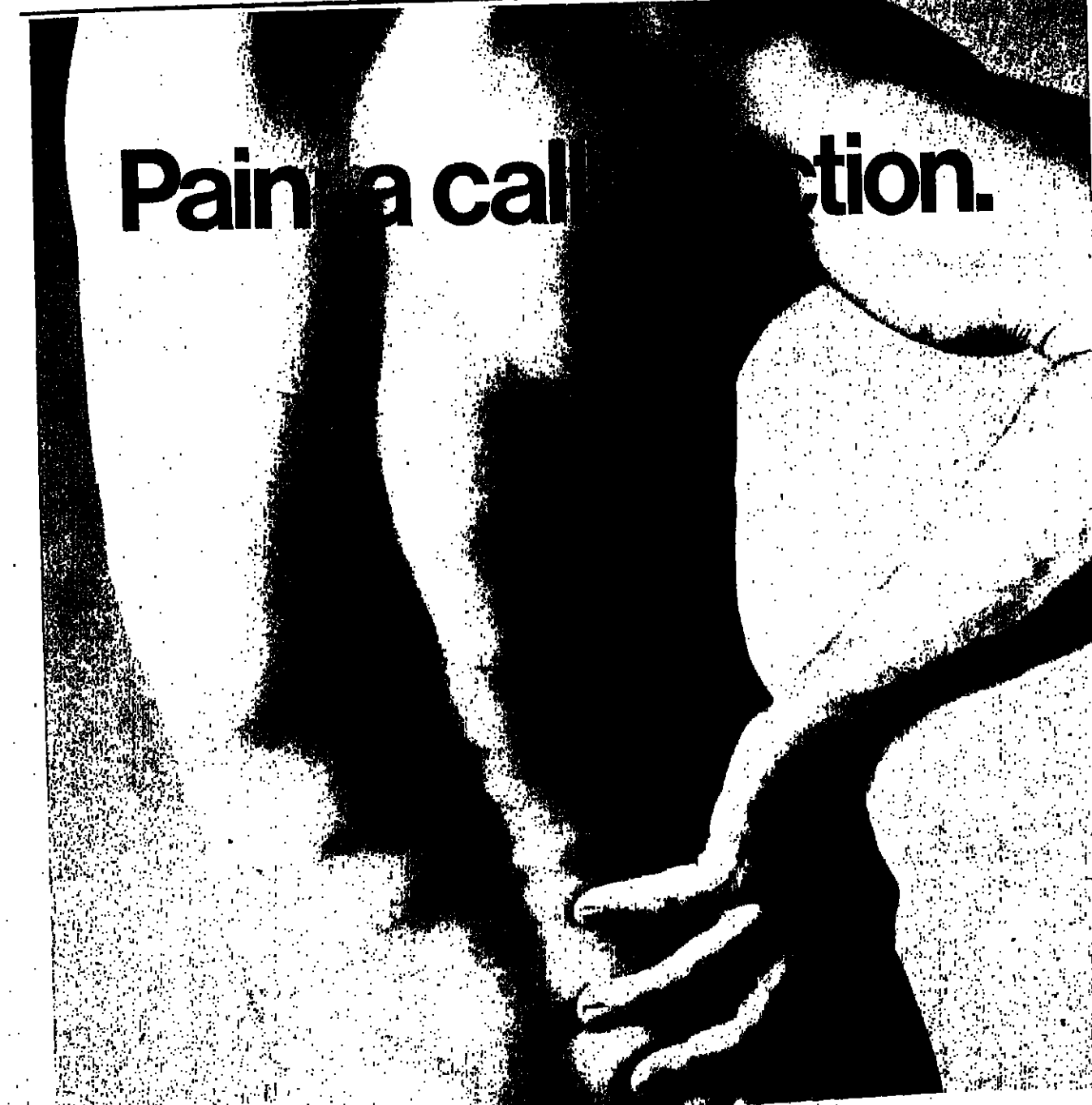
Describing a series of 53 patients, Dr. Schlosser said a synthetic screen filter, mounted on a steel framework, is introduced into the inferior v. cava transvenously under television control from the cervical vein.

The entry of the renal vein is marked by infusion urography with visualization of the renal pelvises, and then the filter is released, hooked up and screwed off the introducing catheter at the level of the 3rd to 4th lumbar vertebra below the renal pelvises.

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Synthetic "umbrella" screen filter, above left, prevents recurrent pulmonary embolism when implanted in the infra-renal vena cava via catheter (also shown). Device is introduced intravenously under television control from cervical vein, then screwed off catheter at the 3rd to 4th lumbar vertebra below renal pelvises.



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See facing page for Brief Summary

\*See dosage and administration section of Brief Summary

Whenever an APC/narcotic is indicated.

Whenever an APC/narcotic is indicated.

## Tablets Percodan<sup>®</sup> C

Each yellow, scored tablet contains 450 mg. oxycodone HCl (Warning: May be habit forming), 32 mg. aspirin, 100 mg. phenacetin, and 32 mg. caffeine. **INDICATIONS:** For the relief of moderate to moderately severe pain.

**CONTRAINDICATIONS:** Hypersensitivity to oxycodone, aspirin, phenacetin or caffeine.

**WARNINGS:** Drug Dependence. Oxycodone can produce drug dependence of the morphine type and, therefore, has the potential for being abused. Psychic dependence, physical dependence and tolerance may develop upon repeated administration of Percodan, and it should be prescribed and administered with the same degree of caution appropriate to the use of other oral narcotic-containing medications. Like other narcotics, oxycodone may produce respiratory depression. It is subject to the Federal Controlled Substances Act.

**Usage in Pregnancy:** Oxycodone may impair the mental and/or physical abilities required for the performance of potentially hazardous tasks such as driving a car or operating machinery. The patient using Percodan should be cautioned accordingly.

**Interactions with other central nervous system depressants:** Patients receiving other narcotic analgesics, general anesthetics, phenothiazines, other tranquilizers, sedative-hypnotics or other CNS depressants (including alcohol) concurrent with Percodan may exhibit additive CNS depression. When such combined therapy is contemplated, the dose of one or both agents should be reduced.

**Dosage in pregnancy:** Safe use in pregnancy has not been established relative to possible adverse effects on fetal development. Therefore, Percodan should not be used in pregnant women unless, in the judgment of the physician, the potential benefits outweigh the possible hazards.

**Other cautions:** Percodan should not be administered to children. Safety should be used with caution in the presence of peptic ulcer or coagulation abnormalities.

**PRECAUTIONS:** Read label and insert. The respiratory depressant effects of narcotics and their capacity to elevate cerebrospinal fluid pressure may be markedly exaggerated in the presence of head injury, other intracranial lesions or a pre-existing increase in intracranial pressure. Further narcotic administration may be hazardous in these conditions. The clinical course of patients with head injuries may obscure the clinical course of patients with head injuries.

**Acute abdominal condition:** The administration of Percodan to other narcotics may obscure the diagnosis or clinical course in patients with acute abdominal conditions.

**Symptoms of overdose:** Percodan should be given with caution to patients with conditions such as the elderly or debilitated, and those with impaired renal or hepatic function, hypotension, Addison's disease, and prostatic hypertrophy or urethral stricture.

**Pharmacological effects:** Percodan may be given with caution to patients with conditions such as the elderly or debilitated, and those with impaired renal or hepatic function, hypotension, Addison's disease, and prostatic hypertrophy or urethral stricture.

**ADVERSE REACTIONS:** The most frequently observed adverse reactions include light-headedness, dizziness, sedation, nausea and vomiting. Some of these adverse reactions may be alleviated if the patient lies down.

Other adverse reactions include anorexia, dysphoria, constipation, and pruritus.

**DOSE AND ADMINISTRATION:** Dosage should be adjusted according to the severity of the pain and the response of the patient. It may occasionally be necessary to exceed the usual dosage recommended before in cases of more severe pain or in those patients who have become tolerant to the analgesic effect of narcotics. The usual adult dose is one tablet every six hours as needed for pain.

**DRUG INTERACTIONS:** The CNS depressant effect of Percodan may be additive with other CNS depressants. See WARNINGS.

**Aspirin may enhance the effect of anticoagulants and inhibit the effect of uric acid excretion.**

**MANAGEMENT OF OVERDOSE:** Signs and Symptoms: Serious overdose with Percodan is characterized by respiratory depression, extreme somnolence progressing to stupor or coma, skeletal muscle flaccidity, cold and clammy skin, and loss of reflexes and respiration. In severe overdose, respiratory arrest, cyanosis, cardiac arrest and death may occur. The ingestion of very large amounts of Percodan may, in addition, result in acute salicylate intoxication.

**Rescue:** Primary attention should be given to the reestablishment of adequate respiratory exchange through patent airway and, if needed, artificial respiration. The narcotic and aspirin components of Percodan are specific antidotes against respiratory depression which may result from overdose or unusual sensitivity to narcotics, including oxycodone. However, an overdosage of one of these components should be identified, preferably by the intravenous administration of naloxone may be given if the oxycodone component is the cause of the overdose. The usual adult dose of the antagonist is 0.4 mg. administered intravenously over a period of one to two minutes. The antagonist should be kept under continuous observation and repeated doses of the antagonist be kept under continuous observation and repeated doses of the antagonist be kept under continuous observation.

**As a narcotic should not be administered to the elderly or debilitated patients with respiratory or cardiovascular depression.**

**Alcohol, barbiturates, tranquilizers, and other sedative drugs should be avoided or limited.**

Endo Laboratories, Inc.  
Sugarcreek, O.E. 44110  
Sugarcreek, O.E. 44110  
Sugarcreek, O.E. 44110

An average of 11.2 months elapsed from surgery to relapse in patients undergoing only surgery. Patients receiving BCG or BCG and 5-FU had averages of 21 and 14.4 disease-free months respectively.

In all patients with colorectal disease, 50 per cent were dead 40 months postoperatively if they did not receive immunotherapy. There were no deaths in patients receiving BCG or BCG plus 5-FU at 16.6 months.



... brief summaries of editorials or comments in current medical and scientific journals.

### The Nondisease Exam

"... If one examines the balance sheet of many physicians ... the cost benefit to the provider in terms of gross and net income from the periodic health examination or screening procedures may be considerable. Many practitioners have too long set the visit fee as the 'loss leader,' while profits arise from the many laboratory tests appended on to the routine—or not so routine—visit. Similarly, reimbursement formulas as established by hospitals and third parties are frequently such that the hospital could not afford to do fewer laboratory tests; abolishing the admission screening that Korvin questions might well push some already hardpressed institutions further towards the brink!

"With this kind of economic incentive firmly entrenched, one has to be realistic about chances for making patterns of medical care more appropriate. ... we must reevaluate the objectives of the periodic health examination. ... we should spend less time and money searching for what is all too often a nondisease." (Editorial, Thomas L. Deblanco, M.D., and John Noble, M.D., Ann. Int. Med. 83:271, Aug., 1975)

### Neglected Principle

"Most emergency abdominal operations have a clear primary mission: to save a life. Often the patient is a subpar surgical risk as a direct result of the condition creating the emergency. A self-evident principle should govern the surgeon's behavior in these situations: the life-threatening condition should be corrected by the safest and simplest means. Yet, at times, otherwise level-headed surgeons seem to depart from this 'common' sense.

"Example: An eighty year old woman correctly undergoes removal of a gangrenous appendix. At the same operation, the surgeon reduces and repairs a large esophageal hiatus hernia suspected from the findings on the chest x-ray film! The result is an undeservedly uncomplicated postoperative course, from which the surgeon erroneously infers that he did the patient a favor. He ignores the risk, which might have cost the patient's life, of prolonging the operation, operating through an infected field, and correcting a situation unrelated to the emergency and probably present for years without causing symptoms ...

"We all have known surgeons, and not all of them young, with the uncanny destructive instinct to do the one additional thing that may lengthen the operation inordinately or lead to postoperative complications and even death. Let us be that surgeon, let us remind ourselves to save life at emergency operations and omit the frills! Who would condone the commercial airline pilot who indulges in aerial acrobatics before safely landing his passenger-filled 747?" (Editorial, Stanley O. Hoerr, M.D., Amer. J. Surg. 130:1, July, 1975)

## Living better with herself



Navane® (thiothixene) Capsules: 1 mg, 2 mg, 5 mg, 10 mg, 20 mg / Navane® (thiothixene hydrochloride) Concentrate: 5 mg/ml, Intramuscular 2 mg/ml

**PRESCRIBING INFORMATION**  
Navane® (thiothixene) Capsules: 1 mg, 2 mg, 5 mg, 10 mg, 20 mg (thiothixene hydrochloride)  
Concentrate: 5 mg/ml, Intramuscular 2 mg/ml

Actions. Navane is a psychotropic agent of the thioxanthene series. Navane possesses certain chemical and pharmacological similarities to the piperazine phenothiazines and differs from the aliphatic group of phenothiazines. Navane's mode of action has not been clearly established.

Indications. Navane is effective in the management of manifestations of psychotic disorders. Contraindications. Navane is contraindicated in patients with circulatory collapse, comatose states, central nervous system depression due to any cause, and blood dyscrasias. Navane is contraindicated in individuals who have shown hypersensitivity to this drug. It is not known whether there is a cross-sensitivity between the thioxanthenes and the phenothiazine derivatives, but this possibility should be considered.

**Warnings:** Use in Pregnancy—Safe use of Navane during pregnancy has not been established. Therefore, this drug should be given to pregnant patients only when, in the judgment of the physician, the expected benefits from its use outweigh the possible risks to mother and fetus. Animal reproduction studies and clinical experience to date have not demonstrated any teratogenic effects.

In the animal reproduction studies with Navane, there was some decrease in conception rate and litter size, and an increase in resorption rate in late pregnancy. Changes which have been similarly reported with other psychotropic agents. After repeated oral administration to rats (6 to 15 mg/kg/day) and mice (10 to 50 mg/kg/day), and monkeys (1 to 5 mg/kg/day) before and during gestation, no teratogenic effects were seen. (See Precautions.)

**Use in Children:** The use of Navane in children under 12 years of age is not recommended because safety and efficacy in the pediatric age group have not been established.

As is true with many CNS drugs, Navane may impair the mental and/or physical abilities required for the performance of potentially hazardous tasks such as driving a car or operating machinery, especially during the first few days of therapy. Therefore, the patient should be cautioned accordingly.

As in the case of other CNS-acting drugs, patients

## relating better to others.

### Disquieting symptoms controlled...

depression · anxiety · erratic behavior · confusion · hostility · agitation

Navane (thiothixene) helps reduce the frequency and intensity of psychotic manifestations related to chronic brain syndrome, which can erect a barrier between the elderly person and those near and dear to him.

### More alert, more active, better able to participate

By effectively relieving such symptoms, Navane helps patients toward a renewed interest in themselves and a revitalized concern for the people and activities around them. And the relative lack of sedation with the use of Navane<sup>1</sup> helps patients remain more alert, more active, and better able to meet the day-to-day demands of life, than prior to treatment.

### Well tolerated in the elderly

Even in elderly patients, Navane produces few side effects that necessitate discontinuance of medication. Hypotension, a particularly important problem in the elderly, is relatively infrequent with Navane;<sup>2,3</sup> as are nonspecific EKG changes.<sup>3</sup> Extrapyramidal symptoms may occur but are usually readily controlled. No agranulocytosis has been reported, nor have any cases of clinically confirmed jaundice been attributed to Navane.

References: 1. Ill, T.M., et al. Scientific Exhibit, presented at the American Public Health Association Conference, Atlantic City, New Jersey, Nov. 12-16, 1972. 2. Birkett, D.J., Hirschfeld, W. and Simpson, G.M. Curr. Ther. Res. 14:775, Dec., 1972. 3. Dillenkopper, R.L., et al. Scientific Exhibit, presented at the 125th Annual Meeting of The American Psychiatric Association, Dallas, Texas, May 1-4, 1972.

## Navane® (thiothixene)(thiothixene hydrochloride)

Capsules 1 mg, 2 mg, 5 mg, 10 mg, 20 mg Concentrate 5 mg/ml Intramuscular 2 mg/ml  
Usual starting dosage: 2 mg t.i.d. to 5 mg b.i.d.

Navane® (thiothixene) Capsules: 1 mg, 2 mg, 5 mg, 10 mg, 20 mg / Navane® (thiothixene hydrochloride) Concentrate: 5 mg/ml, Intramuscular 2 mg/ml

weight, weakness or fatigue, polydipsia and peripheral edema. In some cases the cause of the edema may be a retention of fluid, but in others it may be a result of a systemic lupus erythematosus-like syndrome.

NOTE: Budd-Chiari deaths have occasionally been reported in patients who have received certain phenothiazine derivatives. In some cases the cause of death was apparently cardiac arrest or asphyxia due to failure of the cough reflex. In others, the cause could not be determined nor could it be established that death was due to phenothiazine administration. Dosage should be individually adjusted depending on the chronicity and severity of the condition. In general, small doses should be used initially and gradually increased to the optimal effective level, based on patient response.

Some patients have been successfully maintained on a once-a-day Navane therapy.

Use in children under 12 years of age is not recommended because safe conditions for its use have not been established.

Navane Intramuscular Solution—For intramuscular use only. Where more rapid control and treatment of acute behavior is desirable, the intramuscular form of Navane may be indicated. It is also of benefit in the treatment of acute symptoms of psychosis, whether acute or chronic, renders oral administration impractical or even impossible.

For treatment of acute symptoms of psychosis, the usual dose is 4 mg of Navane intramuscular administered 2 to 4 times daily. Dosage may be increased or decreased depending on response. Most patients are controlled on a total daily dosage of 16 to 20 mg. The maximum recommended dosage is 30 mg/day. An oral form should supplement the injectable form as soon as possible. It may be necessary to adjust the dosage when changing from the intramuscular to oral dosage forms. Dosage recommendations for Navane Capsules and Concentrate are given in the following paragraphs.

**Navane Capsules:** Navane Concentrate—in milder conditions, an initial dose of 2 mg three times daily, if indicated, a subsequent increase to 15 mg/day total daily dose is often effective.

In more severe conditions, an initial dose of 8 mg three times daily.

The usual optimal dose is 20 to 30 mg daily. If

indicated, an increase to 60 mg/day total daily dose is often effective. Exceeding a total daily dose of 60 mg rarely increases the beneficial response.

Overdose. Manifestations include muscular twitching, drowsiness, and dizziness. Symptoms of gross overdose may include CNS depression, rigidity, weakness, laryngitis, tremor, salivation, dysphagia, hypotension, disturbances of gait, or coma.

Resistant. Essentially symptomatic and supportive treatment. For Navane oral, early gastric lavage is helpful. For Navane oral, early gastric lavage is helpful. For Navane oral, early gastric lavage is helpful.

If a vasopressor is needed, levorotational and other sympathomimetic amines are not recommended since these agents may reverse the usual pressor effect of these agents and cause further lowering of blood pressure.

If CNS depression is present, recommended stimulants should be avoided. Extraparasympathetic symptoms may be treated with anticholinergic drugs.

There are no data on the use of Navane in patients with renal or hepatic impairment.

Navane (thiothixene hydrochloride) Concentrate is available in 100 ml (4 oz.) bottles with an accompanying dosing syringe. Each ml contains thiothixene hydrochloride equivalent to 5 mg of thiothixene (thiothixene hydrochloride) U.S.P. 7.0% w/v (small ampules available).

Navane (thiothixene hydrochloride) Intramuscular Solution is available in 2 ml amber glass vial in solution in 100 ml (4 oz.) bottles. Each ml contains thiothixene hydrochloride equivalent to 5 mg of thiothixene (thiothixene hydrochloride) U.S.P. 7.0% w/v, and propyl glycol 2.0% w/v, benzyl alcohol 0.5% w/v.

More detailed professional information available on request.

## Colorectal Cancer A Major Problem —Little Progress

Medical Tribune Report

HOUSTON—Colorectal cancer "has been a major public health problem for the last 20 years though little progress has been made in treatment," said Dr. Giora Mavligit, Associate Professor of Medicine, the University of Texas Health Science Center at Houston. He predicted that in 1975, 100,000 new cases of colorectal disease will be discovered and that half will die.

"Diagnosing fast and early, a good surgical report, good analysis by the pathologist and knowing the number, location and geography of involved lymph nodes will improve the prognosis of patients with colorectal cancer," he said at a seminar on the medical management of malignancy sponsored by the M. D. Anderson Hospital and Tumor Institute.

He urged pathologists to count all nodes and surgeons to remove as many nodes as possible in the area of resection. "Chemotherapy is more effective with a small amount of tumor than with cancer all over," he said.

### Risk of Recurrence

Twenty to 30 per cent of colorectal cancer cases involve disease through the wall and fat as well as regional lymph nodes. Radiation of the recto-cum preoperatively is of some value, but chemotherapy has a marginal effect without statistical significance.

After surgical removal of the tumor, these patients run a high risk of recurrence, 50 per cent at 16 months, with 32 per cent having a five-year survival. Seventy-five per cent of cases will be failures, Dr. Mavligit said.

Although the surgeon may say he's cured the patient, often there are tumor cells left after surgery, Dr. Mavligit said. Micrometastases to the liver should be targets of adjuvant therapy, either BCG or BCG plus 5-FU, he indicated. "BCG kills a certain fraction each time it is administered so it must be given repetitively," he said. Dr. Mavligit administers BCG by scarification on a weekly basis.

"Chemotherapy will kill most cells and immunotherapy, 'the last cell,' the investigator stated. He speculates that there may be synergism between immune response and chemotherapy.

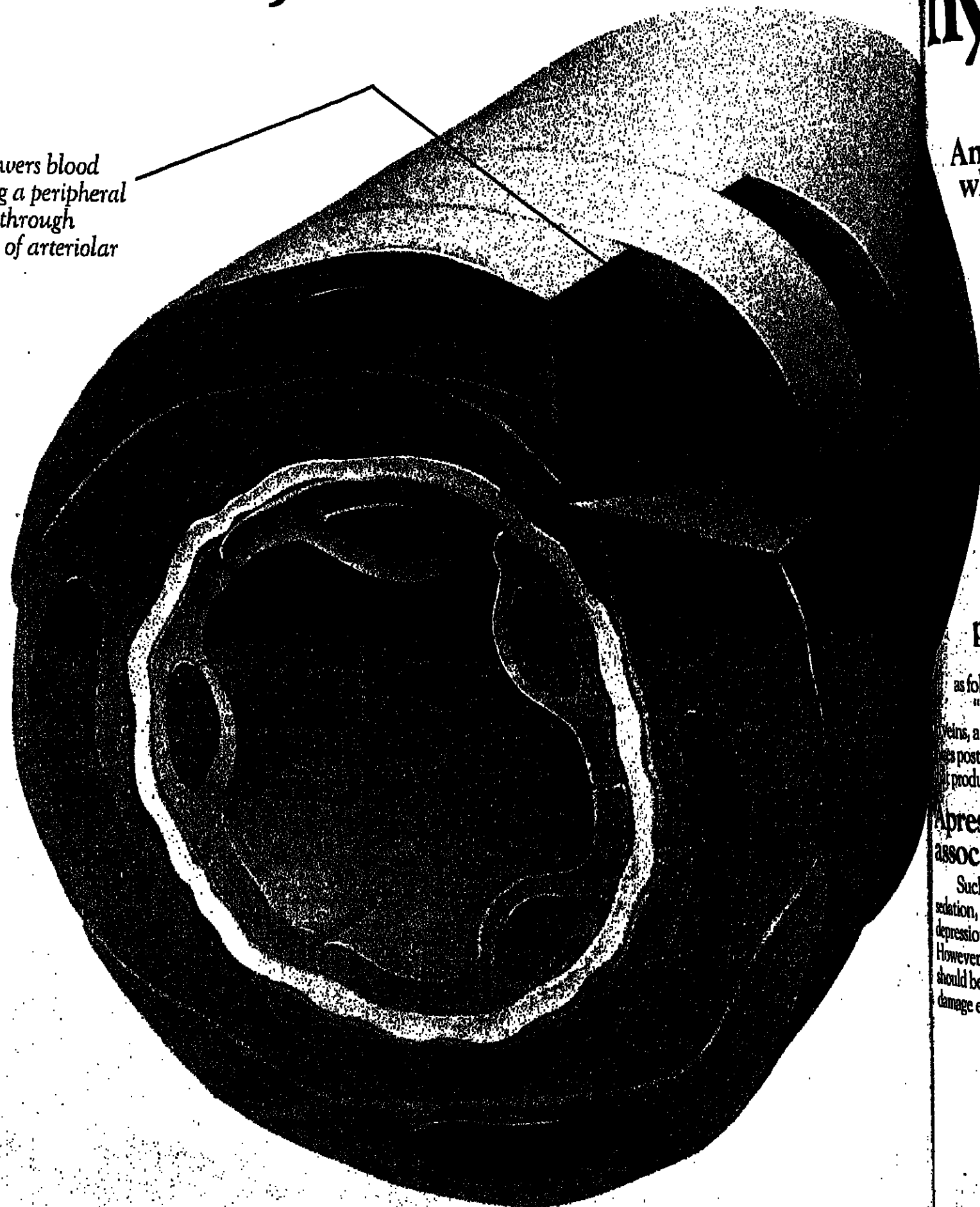
In a group of patients with five or more positive nodes receiving either BCG or BCG and 5-FU, survival was longer than in those patients who underwent surgery alone. There were no deaths in the group receiving combination therapy after 30 months and 25 per cent of the treated group were alive after 41 months.

An average of 11.2 months elapsed from surgery to relapse in patients undergoing only surgery. Patients receiving BCG or BCG and 5-FU had averages of 21 and 14.4 disease-free months respectively.

In all patients with colorectal disease, 50 per cent were dead 40 months postoperatively if they did not receive immunotherapy. There were no deaths in patients receiving BCG or BCG plus 5-FU at 16.6 months.

# Apresoline...where the action is in treating hypertension

Apresoline lowers blood pressure by exerting a peripheral vasodilating effect through a direct relaxation of arteriolar smooth muscle.



## An antihypertensive idea whose time has come

Doctors who treat hypertension are increasingly interested in the one oral drug that has a mechanism of action exclusively its own — Apresoline.

Apresoline is in an antihypertensive class by itself because it reduces blood pressure through a unique mechanism. Acting at the ultimate site of hypertension, it directly relaxes arteriolar smooth muscle to decrease peripheral vascular resistance and arterial pressure. As blood pressure falls, there is an accompanying rise in cardiac output and rate.

Apresoline also maintains or increases renal and cerebral blood flow.

## Apresoline minimizes postural hypotension

Nickerson<sup>1</sup> describes the action of Apresoline as follows:

"A preferential effect on arterioles, as compared with veins, allows the increase in cardiac output and minimizes postural hypotension; the latter is much less than produced by agents blocking sympathetic nerves."

## Apresoline avoids side effects associated with other agents

Such untoward reactions as drowsiness, lethargy, sedation, sexual dysfunction, and exacerbation of mental depression are not usually encountered with Apresoline. However, as with any antihypertensive agent, hydralazine should be used with caution where advanced renal damage exists.

## Apresoline helps tailor the regimen to the patient

When Apresoline is added to an existing antihypertensive regimen, it introduces a different and complementary pharmacologic approach to the control of your patient's hypertension.

Apresoline thus affords the physician a variety of combinations with which he can construct regimens more closely molded to individual requirements. According to Freis,<sup>2</sup> such a combination of drugs, each with a different antihypertensive mechanism, is the most effective way to control blood pressure. This may also permit lower drug dosages.

Apresoline lends itself admirably to the contemporary antihypertensive rationale and its therapeutic goals: more vigorous and more effective control of blood pressure through a plurality of mechanisms.

## Apresoline: used effectively in the VA studies

Apresoline was one of the three basic drugs used in two published VA cooperative studies.<sup>3,4</sup>

**References:** 1. Nickerson M. Antihypertensive agents and the drug therapy of hypertension. In: Gosselin I, Gilman A (eds): *The Pharmacological Basis of Therapeutics*, 4th ed. New York, The Macmillan Company, 1970, p 729. 2. Freis ED. Hypertension: a curable disease. *Clin Pharmacol Ther* 13:627-632, 1972. 3. Veterans Administration Cooperative Study Group on Antihypertensive Agents. JAMA 202:1028-1034, 1967. 4. Effects of treatment on morbidity in hypertension. II. Results in patients with diastolic blood pressure averaging 90 through 114 mm Hg. Veterans Administration Cooperative Study Group on Antihypertensive Agents. JAMA 213:1143-1152, 1970.

Next page: Apresoline (hydralazine) and the Hypertension Task Force

### Apresoline<sup>®</sup> (hydralazine hydrochloride)

**INDICATIONS:** Essential hypertension, alone or as an adjunct, in the treatment of coronary artery disease, mitral valve disease, and other heart diseases.

ing to a clinical picture simulating acute systemic lupus erythematosus. This may also occur at onset of therapy, but long-term treatment with steroids may be necessary and relapse have been detected many years later. Complete blood counts, L.E. cell preparations and antinuclear antibody titer determinations are indicated before and periodically during prolonged therapy, even though patients are asymptomatic. These studies are particularly important in the presence of any unexplained symptoms.

**Use in Pregnancy:** The drug should be used only when, in the judgment of the physician, it is deemed essential to the welfare of the patient.

And addition of pyridoxine to the regimen if symptoms develop. Blood dyscrasias, consisting of reduction in hemoglobin and red cell count, leukopenia, agranulocytosis, and purpura, have been reported rarely. Periodic blood counts are advised during prolonged therapy.

**ADVERSE REACTIONS:** Common: Headache, palpitations, anorexia, nausea, vomiting, diarrhea, tachycardia, angina pectoris, loss of appetite, nasal congestion, flushing, lacrimation, conjunctivitis, peripheral neuritis.

**DOSE:** Initiate therapy in gradually increasing dosage, adjusted according to individual response. Start with 10 mg 4 times daily for the first 2 to 4 days, increase to 20 mg 4 times daily for balance of first week. For second and subsequent weeks, decrease dosage to 10 mg 4 times daily. For maintenance, adjust dosage to lowest effective level.

For patients with renal impairment, particularly the L.E. cell syndrome, in whom the drug is plasma-requiring, large doses of Apresoline may be required for a prolonged period.

Tablets, 100 mg (peach, dry-coated); bottles of 100. Consult complete literature before prescribing.

CIBA Pharmaceutical Company, Division of CIBA-GEIGY Corporation, Summit, New Jersey 07901.

C I B A



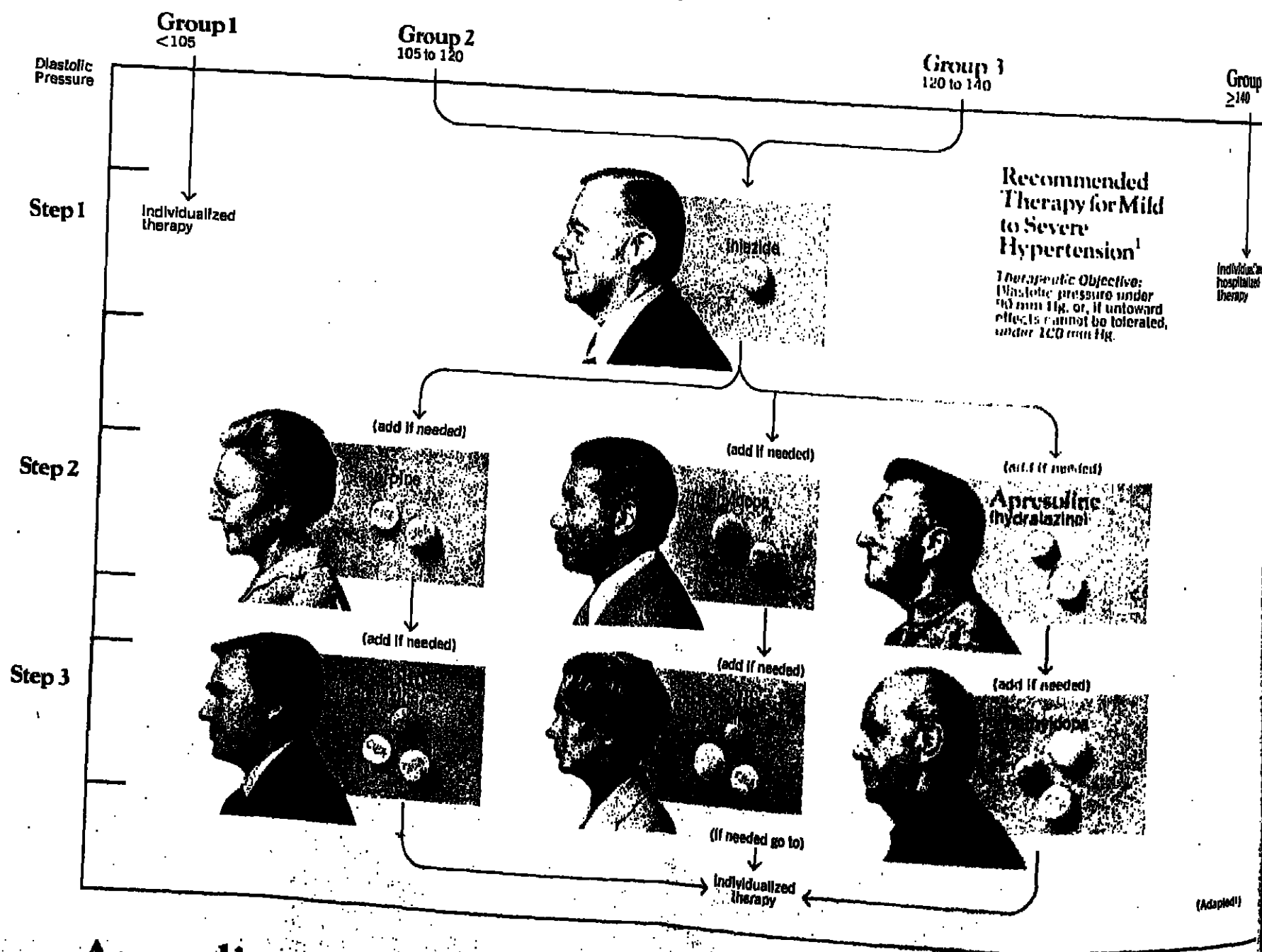
# Apresoline... (hydralazine) part of the Hypertension Task Force "plan of action"

In September 1973, Task Force I of the National High Blood Pressure Education Program recommended a series of antihypertensive regimens for groups with hypertension ranging from mild to severe. Hydralazine—used in combination with sympathetic-inhibiting and/or diuretic antihypertensive

agents—was a specific recommendation for "second step" and "third step" therapy in patients with diastolic pressures ranging from 105 to 140 mm Hg. Hydralazine played a prominent role in the Task Force regimens because of its compatibility with almost any antihypertensive regimen. For

Apresoline can be combined advantageously with nearly all diuretics and sympathetic inhibitors.

Reference: 1. Report of Task Force I, National High Blood Pressure Education Program: Recommendations for a National High Blood Pressure Program Data Base for Effective Antihypertensive Therapy, Sept. 1, 1973, DHEW Publication No. (NIH) 74-553.



Apresoline (hydralazine)  
...acts directly at the ultimate  
site of hypertension  
...brings something  
special to almost any  
antihypertensive  
regimen

For full prescribing information,  
please see preceding pages.



CIBA

Wednesday, November 5, 1975

MEDICAL TRIBUNE

11

The Only Independent Weekly Medical Newspaper in the U.S.

## Medical Tribune

and Medical News  
Published by Medical Tribune, Inc.

### A Watergate-Like Stench

LET US NEVER FORGET that Watergate was not a simple political manipulation but the fundamental violation of American civilian rights—through subversion of the electoral process. Let us not forget that it was carried forward by a regime cloaked in the mantle of "law and order."

And let us now remember that part of the totality of the fraud perpetrated upon the American people was the creation of a drug abuse hysteria.

There is not the slightest doubt that problems of drug abuse exist. But, what was a genuine social ill and medical concern was manipulated for primarily political purposes. The real drug addiction and abuse problems in the United States relate, without any serious contention, to alcohol and cigarettes.

False issues lead to distorted perspectives and as a result a law was passed (Controlled Substances Act of 1970) in which, over the repeated protests of MEDICAL TRIBUNE, important therapeutic agents were stigmatized by association with strong drugs of abuse. Hospitals and doctors became burdened with more red tape paperwork. A new "drug regulatory agency" was created and the control of a huge sector of therapeutics was vested in the Justice Department's Drug Enforcement Agency. MEDICAL TRIBUNE at that time warned of the dangers of a "police" approach to medical problems and the potential threat to the rights of scientists.

The outcome is even more nightmarish than the prophecy.

First, in the last two years the use of hard drugs such as heroin and cocaine has increased—not decreased. Despite the deceitful claims of those seeking to enlarge the bureaucracy and despite the stupid claims of those consumerists who claimed that psychopharmacologic agents lead to major drug abuse, the facts reveal the opposite. There never

was a correlation between the physician's prescribing of psychopharmaceuticals, in largest measure to middle-aged white women, and the use of hard drugs which relates to adolescent or young black and white males. The result was an impediment of medical therapeutics, a threat of shortage of therapeutic morphine, and the unimpeded growth of the vicious and disgusting hard drug problem we confront.

Second, the civil rights of individuals were violated, not just those of a Jane Fonda, but of simple, private families whose homes were violently broken into. The Justice Department, which should have set standards of probity, demonstrated the dangers implicit in the arrogancy of power even in a democratic society. The violations of a psychiatrist's office was part of a complex of despicable actions which are now subsumed under the rubric of the generic term, Watergate.

Third, as though this were not enough, we are learning that the C.I.A. likewise became involved and in its maneuvers within the Drug Enforcement Agency engaged in a pattern of illegal actions within the country.

Fourth, at a time when it was impossible without forfeiting one's academic rights to continue research on LSD, it is now revealed that a secret program of LSD administration "to unsuspecting subjects to learn its effects" was associated with the death of a high level military researcher in biological warfare. His family is quoted as stating that "Without his knowledge or consent [he had] been given LSD by two C.I.A. employees during [a] research meeting."

Science, and particularly the biomedical sciences, must be protected from abuse as a publicity vehicle or as a political football if we are to continue to have a free and democratic science and a healthier society. A.M.S.

### We Must Be Doing Something Right

THE TOP ADMINISTRATORS for health of the Department of Health, Education and Welfare have just issued the second Forward Plan for Health, aimed at the five-year period for fiscal years 1977-1981. We quote from the section on current health status: "After a decade of stable mortality rates in the United States, the age-adjusted mortality rates have again shown a steady decline of one per cent per year since

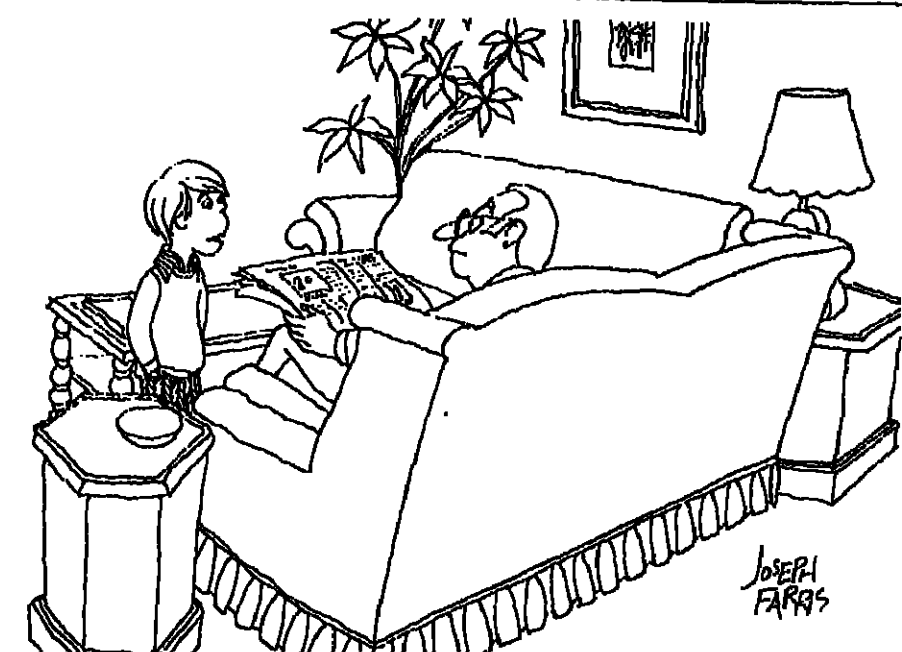
1968. The causes of the leveling off during the preceding decade and the recent renewed downturn are not as yet well understood."

Perhaps the causes "are not as yet well understood" but as the title of a recent editorial put it, "We must be doing something right. Curiously enough, the studies of health care in this country have not chosen to publicize this good news."

### Transposed Great Arteries

CLINICAL QUOTE: "Twenty days after surgery [the infant's] pulmonary pressure was 25/13 mm Hg and the pressure in the right ventricle was 3,700 at the time of surgery." (Dr. A. D. Jatene, Professor of Surgery, Cardiac Institute, Sao Paulo, Brazil, describing the first patient ever to undergo total anatomic correction for transposition of the great arteries. See page 1.)

re-evaluated and considered in very good condition, without cyanosis. He presently weighs 5,500 grams against 3,700 at the time of surgery." (Dr. A. D. Jatene, Professor of Surgery, Cardiac Institute, Sao Paulo, Brazil, describing the first patient ever to undergo total anatomic correction for transposition of the great arteries. See page 1.)



"Say, Dad, was a dollar ever worth a dollar?"

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### LETTERS TO TRIBUNE

#### Shin Splints and Arches

I agree with Dr. Robert D'Ambrosia [MT, Sept. 24] that the term "shin splints" should be more sharply defined. It should be limited to disorders of the anterior compartment. This is the true "shin splints."

What Dr. D'Ambrosia describes is another frequent problem, pain in the posterior tibial muscle, its attachment to the tibia and its tendon.

Treatment for this disorder consists in focusing on its function. Its tendon forms a sling for the arch and supinates the foot. The runner with an unstable pronating foot pulls on this tendon, the muscle and its attachment to the tibia. My experience, however, is that the pain is mostly in the muscle and its tendon.

The treatment? Support to an hypermobile pronating first metatarsal segment and a collapsing arch. SIXXO foot strikes an hour can create havoc in this supporting muscle tendon complex. Shoes with good heel counters and solid shanks are a help, but usually a flexible non-compressible arch support is necessary. Do-it-yourself felt supports sometimes do the trick, but frequently help from an experienced sports podiatrist is necessary.

GEORGE A. SHEEHAN, M.D.  
Red Bank, N.J.

#### Ode to Diabetes Hearings

Your report of the F.D.A. diabetes hearings prompted the following:

Oh, We Need To Design Many  
Walters To Sign

Praise be to Prout  
Whom we've heard out  
These many years  
Arousing fears,  
With religious zeal,  
Seeking repeal  
Of F.D.A. approval,  
And near total removal  
Of oral agents  
That (?) kill patients.

Now in this crusade,  
To abet and aid  
Dr. Prout in his fight

To protect the right  
Of the people to know  
What the doctors don't know,  
Is unadmitted Sid,  
Now making his bid,  
For the hero's place—  
The consumer's good grace.

Unadmitted, I say,  
'Cause I'll bet 'til this day  
Sid Wolfe never treated  
Diabetes, nor needed  
The dastardly pill,  
Which he believes can kill;  
But the rest of us use  
To relieve those who choose  
To ask us for relief  
Of considerable grief,  
Caused by these "polys"  
Of untreated diabetes,  
And itching of skin  
And blurring of vision,  
Loss of weight and strength—  
I could go on at length.

For be it from me  
To judge U.G.D.P.,  
But pills I don't give  
To diabetics who live  
In a comfortable state  
With their glycemic fate,  
And do not bemoan  
Diet alone.

Could it just be  
That U.G.D.P.  
May have killed some cases  
With Orinases,  
By giving the pill  
To patients not ill,  
Only hyperglycemic—  
Then hypoglycemic,  
With too much catechol  
For a diseased heart's control,  
Causing V. Tach—  
Then heart attack.

Sometimes, like the pills,  
When insulin kills,  
It's hard to see  
At the autopsy,  
How the patient died  
From lack of sacharide.

Oh, we need to design  
More walters to sign!  
NELSON G. GOODMAN, M.D.  
Bowie, Md.

# SPECIFIC SYMPTOM: NONPRODUCTIVE COUGH



## SPECIFIC RX: **Hycotuss** EXPECTORANT

Because specific symptoms require specific therapy, Hycotuss® Expectorant was formulated to specifically treat nonproductive cough associated with respiratory tract congestion.

Hycotuss® Expectorant contains hydrocodone bitartrate, a highly effective antitussive, and glyceryl guaiacolate which acts to liquify and dislodge viscous secretions in the bronchi.

**Relieves persistent coughing while it helps liquify bronchial secretions**

DESCRIPTION Each teaspoonful (5 ml) contains:

Hydrocodone Bitartrate 5 mg  
Glyceryl Guaiacolate 100 mg  
Alcohol U.S.P. 10% v/v  
Hydrocodone is 7, 8-dihydrocodeinone, a derivative of codeine.

ACTIONS Hydrocodone is a centrally acting narcotic antitussive providing cough relief for up to 6 hours. Glyceryl guaiacolate assists the expectorant action by producing a less viscous mucus thereby facilitating its expulsion.

INDICATIONS Indicated for the symptomatic relief of coughs. Especially useful in unproductive coughs associated with upper and lower respiratory tract congestion.

CONTRAINDICATIONS Hycotuss® Expectorant should not be used in patients with hypersensitivity to hydrocodone or glyceryl guaiacolate.

WARNINGS Hycotuss® Expectorant should be prescribed and administered with the same degree of caution appropriate for the use of other oral narcotic-containing medications since it can produce drug dependence and, therefore, has the potential for abuse. Patients should be warned not to drive a car or operate machinery if they become drowsy or show impaired mental and/or physical abilities while taking Hycotuss® Expectorant. Patients receiving narcotic analgesics, phenothiazines, other tranquilizers, sedative-hypnotics or other central nervous system depressants (including alcohol) concomitantly with Hycotuss® Expectorant may exhibit an additive central nervous system depressant effect. When such combined therapy is contemplated, the dose of one or both agents should be reduced.

PRECAUTIONS Before prescribing medication to suppress or modify cough, it is important to ascertain that the underlying cause of cough is identified, that modification of cough does not increase the risk of clinical or physiologic complications, and that appropriate therapy for the primary disease is provided.

ADVERSE REACTIONS Adverse reactions, when they occur, include sedation, nausea, vomiting and constipation.

DOSE AND ADMINISTRATION Hycotuss® Expectorant should be taken after meals and at bedtime, not less than 4 hours apart. Treatment should be started with the suggested initial dose and subsequent doses adjusted if required.

Usual Dosage

SYRUP teaspoonful (5ml)

Initial dose

Maximum single dose

Adults

Children over 12 years

2 to 12 years

under 2 years

Dosage should be calculated as follows: 0.3 mg/kg/24 hrs., divided into four equal doses.

HOW SUPPLIED In bottles of one pint and one gallon.

Oral prescription when permitted by State law.

Endo Laboratories, Inc.

2700 E. 12th Avenue, Denver, CO 80202

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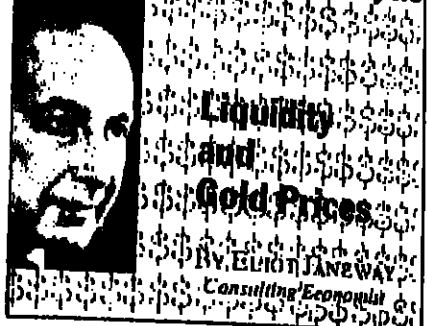
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## Tribune Economic Analysis



From here on out, the more the rate of inflation jumps, the more it will dry up the liquidity available to everyone. Roosevelt's purpose in raising the price of gold in the depression of the 1930s was explicitly and unequivocally to undo the ravages of deflation and to start up the corrective momentum of inflation. Roosevelt may have been an economic illiterate—no doubt practical politicians always are. But he grasped the marketplace reality that raising the price of gold primes the pump for inflation—provided liquidity is abundant enough to support the exercise. This was in Roosevelt's time. The opposite is the case now.

### Spiraling Interest Rates

The resurgence of inflation is the direct and inescapable reason for the renewed spiraling of interest rates. Today, 7 per cent in tax-exempt income—14 per cent to anyone in a 50 per cent bracket—is no trick for investors willing to tie up money for a year. But money is too scarce and too scared to take advantage of this rate of return. Anytime money is unwilling and unable to accept bonus pay for the privilege of going to work, it's not likely to volunteer for the chance to shoot craps in the gold game.

It's little wonder that the very governments which the gold bugs counted on to bull the price of gold are now breaking it. The liquidity crunch is hurting them most. Governments are under the 'most urgent and endless pressure to raise cash. The actual announcements of sales from official government holdings are only the tip of the iceberg. No private speculators can hope to support the gold market when distress government selling is breaking it.

### Ask Janeway

Would you recommend a retired couple invest the majority of their funds in bonds? We are considering BBB-rated utility bonds and long-term Treasury bonds because income is our highest priority. However, this would tie up funds for an extended period of time and would provide only minimum flexibility.

Medical Couple, M.D. & R.N.

What about conserving your capital? Your thinking would expose you to capital losses as interest rates continue to rise. Retirees may regard themselves as realistic in subordinating growth and gain to income, but they are actually being extremely unrealistic. As retirees you will have no chance to earn back any losses this thinking locks you into.

Send your questions on finances, investments, taxes to Janeway, MEDICAL TRIBUNE, 880 Third Avenue, New York, N.Y. 10022

## IN CONSULTATION

### What's New and Important in Ophthalmology?



#### The Consultant

DR. ANTONIO R. CASSI  
Assistant Professor of Ophthalmology  
University of Florida College of Medicine

PERHAPS THE GREATEST ADVANCE in the treatment of corneal disease in over a decade has been the development of the soft contact lens and its use as a "bandage." Innumerable cases of severe blinding keratitis (corneal disease) have been cured or controlled through this relatively simple and inexpensive mode of therapy. Patients have been treated who had previously undergone almost all known medical and surgical modalities in an unsuccessful attempt to control the disease process or to restore vision. In the overwhelming majority of cases, soft lens therapy has been able to provide relief of pain, control of the underlying disease process, to promote the healing of damaged and diseased tissue, and, in many cases, to improve or to restore vision.

What are the characteristics distinguishing the hard contact lens from the soft contact lens?

Soft contact lenses are made of a type of hydrophilic or water-absorbent plastic. They have the brittleness of a cornflake when dry, but become soft and pliable when saturated with water, saline or tears. When placed on the eye, they mold themselves to the shape of the cornea, offering considerably more comfort than hard lenses, particularly in the early stages of wear. Because of their softness, they tend to minimize irritations, cornea swelling and abrasions sometimes caused by hard lens wear.

Hard contact lenses are made of methylmethacrylate or plexiglass, a material that provides excellent visual acuity in a wide range of visual defects. Since soft contact lenses weigh more than hard contact lenses, they have to be fitted slightly larger than the cornea diameter. They range in diameter from 12.3 to 15.5 mm. Hard lenses, in contrast, are presently fitted from 7.00 to 9.00 mm in diameter and don't quite cover the cornea. Due to the fact that these lenses are fitted larger than the cornea, one of the major problems of hard lens wearers—dirt specks or particles lodging under the lens—seldom arises with soft lenses.

When is the soft contact lens used therapeutically?

Eyes that are treated with the bandage lens are nearly always seriously diseased. With it the practitioner is able to bring comfort to patients who have had pain for years. This is a dramatic benefit that can be achieved in many cases by no other form of therapy now available. Soft contact lenses have helped to relieve pain and restore

For routine use of contact lenses, when should the hard contact lens be prescribed? When the soft lens?

This should be the choice of the individual, with the proper aid and consultation of his doctor. For optical reasons, there are persons who will see better with hard or soft contact lenses. Since soft lenses take the shape of the cornea, they tend to reproduce corneal astigmatism without correcting it. In these cases, both eye glasses and hard lenses can correct the blurring of vision caused by corneal astigmatism.

Another type of astigmatism, lenticular astigmatism, caused by an irregularity of the natural lens, is corrected only by eye glasses. In many cases, lenticular astigmatism itself corrects corneal astigmatism, eliminating the necessity of correction by accessory lenses. But it is also not uncommon to find that elimination of corneal astigmatism by hard contact lenses will result in the production of residual astigmatism or the bringing out of lenticular astigmatism with its blurring of vision. That this residual astigmatism has not been a significant drawback in the fitting of hard contact lenses stems from the fact that most patients find some degree of residual astigmatism quite tolerable if the other refractive errors are corrected.

While corneal astigmatism was assumed by some to be the main limiting factor in the wear of soft contact lenses, it has actually been a problem in only about 5 to 10 per cent of the population. More important, in fact, are the fluctuations in vision. These fluctuations are experienced as alternate blurring and clearing of vision. The main cause of vision fluctuation with soft lenses is the fit of the lens. Individual corneas vary in diameter and curvature. Although a soft lens tends to take the shape of the cornea, it may not provide a perfect match even though it may feel comfortable. A poor match with a hard lens would cause corneal swelling, pain and discomfort; with a soft lens it is the vision that suffers.

If a soft lens is too curved for the cornea, it gets pressed in and out during blinking, causing alternate blurring and clearing of vision. If it is too small in diameter or too flat, it will move up and down with each blink or it will be displaced laterally and invariably it will cause fluctuations in vision. This fluctuation in vision caused by the early "Model-T" of the hydrophilic lenses has been greatly corrected by the introduction of lenses with different base curves. Vision fluctuation will probably be completely eliminated in the near future. The visual acuity obtainable in a given patient with a given refractive error is dependent not only on the patient and the refractive error, but also upon the expertise of the fitter and, to an extent, upon the availability of lenses of different base curves and diameters. Many people desire contact lenses for different purposes. The individual with a high degree of corneal astigmatism who can't wear hard contact lenses may be satisfied with this alternative for sports and social activities while wearing eye glasses when driving a car or reading a book. Since the main advantages of soft

## New Study of Sclerosis



Dr. Harry Bartfield, St. Vincent's Hospital and Medical Center, New York, will coordinate new multidisciplinary study of amyotrophic lateral sclerosis over next two years with NIH funding of \$600,000-plus.

lenses are comfort and ease of adaptation, successful hard contact lens wearers should not be encouraged to switch from hard to soft contact lenses.

What problems do patients have with initial and prolonged use?

After many years and millions of patients wearing contact lenses, both hard and soft lenses have passed the test of time and have proven themselves both safe and effective. Certainly, however, many minor problems still remain with initial and prolonged use of these lenses.

It is said that for every person who successfully adjusts to hard contact lenses, another gives up because of intolerance to the lenses. Although tolerance has been significantly improved with the introduction of the semi-flexible, thin, small, hard contact lens, poor tolerance to a hard foreign body still remains the main problem. In nearly every respect, the soft contact lens is much kinder to the eye than the hard contact lens and is extremely well-tolerated by patients.

Hard contact lenses are more prone to cause corneal edema than soft. When the edema is light and superficial, the patient sees a great cloud over all objects. When the edema becomes more marked, the patient will notice brightly colored halos around light. A poorly fitted hard contact lens can cause a great deal of corneal edema in a relatively short time. Even a well fitted hard lens can cause corneal edema or injury of corneal epithelium. On the other hand, soft lenses are almost free of this unpleasant side effect. Soft lenses can be worn during all waking hours either from the first day or very shortly after the beginning of adaptation. Hard lens wearers suffer a loss of tolerance for the lens if they don't wear it on a rather regular basis for quite a few hours every day. The soft lens wearer can abandon the lens for as long as he or she wishes and start wearing it again any time without ill effects. Intermittent social wear is therefore a considerable advantage of this type of lens.

Hard contact lenses, particularly the old, large and thick lenses, when worn for long periods of time can produce a temporary change in the shape of the cornea. Patients are often 'incom-

Continued on page 14



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**Relieves persistent coughing while it helps liquify bronchial secretions**

### Usual Dosage:

Adults 1 teaspoonful every four hours, after meals and at bedtime.

Children (Over 12 years) same as adults. (2 to 12 years) ½ teaspoonful every four hours and at bedtime.

Note: Telephone Rx's may be refilled 5 times within 6 months. Telephone Rx's permitted in most states.

### DESCRIPTION Each teaspoonful (5 ml) contains:

Hydrocodone bitartrate..... 5 mg

Warning: May be habit forming

Glyceryl guaiacolate..... 100 mg

Alcohol U.S.P. 10% v/v

Hydrocodone is 7, 8-dihydrocodeinone, a derivative of codeine.

ACTIONS Hydrocodone is a centrally acting narcotic antitussive providing cough relief for up to 6 hours. Glyceryl guaiacolate exerts its expectorant action by producing a less viscous sputum thereby facilitating its expectoration.

INDICATIONS Indicated for the symptomatic relief of coughs. Especially useful in unproductive coughs associated with upper and lower respiratory tract congestion.

CONTRAINDICATIONS Hycotuss® Expectorant should not be used in patients with hypersensitivity to hydrocodone or glyceryl guaiacolate.

WARNINGS Hycotuss® Expectorant should be prescribed and administered with the same degree of caution appropriate for the use of other oral narcotic-containing medications. It has produced drug dependence and, therefore, has the potential for abuse. Patients should be warned not to drive a car or operate machinery if they become drowsy or show impaired mental and/or physical abilities while taking Hycotuss® Expectorant. Patients receiving narcotic analgesics, phenothiazines, other hypnotics, sedatives, tranquilizers or other central nervous system depressants (including alcohol) concomitantly with Hycotuss® Expectorant may exhibit an additive central-nervous system depression. When such combined therapy is contemplated, the dose of one or both agents should be reduced.

### PRECAUTIONS Before prescribing medication to suppress or modify cough, it is important to ascertain that the underlying cause of cough is identified. This modification of cough does not increase the risk of clinical or physiologic complications, and that appropriate therapy for the primary disease is provided.

ADVERSE REACTIONS Adverse reactions, when they occur, include sedation, nausea, vomiting and constipation.

DOSE AND ADMINISTRATION Hycotuss® Expectorant should be taken after meals and at bedtime, not less than 4 hours apart. Treatment should be started with the suggested initial dose and subsequent doses adjusted if required.

Usual Dosage

SYNOPSIS (5 ml)

Initial dose

Maximum single dose

Adults

Children

over 12 years

2 to 12 years

under 2 years

Dosage should be adjusted as Hydrocodone, 0.3 mg/kg/24 hrs., divided into four equal doses.

DRUG INTERACTIONS The central nervous system depressant effect of Hycotuss® Expectorant may be additive with that of other central nervous system depressants. See WARNINGS.

MANAGEMENT OF OVERDOSE Signs and symptoms: Serious overdose with Hycotuss® Expectorant may be characterized by respiratory depression, extreme somnolence progressing to stupor or coma, skeletal muscle flaccidity, cold and clammy skin, and sometimes bradycardia and hypotension. In severe overdosage, apnea, circulatory collapse, cardiac arrest and death may occur.

Treatment: Primary objective should be given to the reestablishment of a patent airway and the institution of assisted or controlled ventilation. The narcotic antagonist naloxone, respiratory depression which may result from overdosage or unusual sensitivity to narcotic, including hydrocodone, administered, preferably by the intravenous route, simultaneously with efforts of respiratory resuscitation. An appropriate dose of one of these antagonists should be administered as needed to maintain adequate respiration. Oxygen, intravenous fluids, vasopressors and other supportive measures should be employed as indicated. Gastric lavage should be considered if the patient is conscious and has not vomited. Activated charcoal may be of benefit.

HOW SUPPLIED In bottles of one pint and one gallon.

DRUG PRESCRIPTION Where permitted by State law.

See Brief Summary for prescribing information.

Endo Laboratories, Inc.

Subsidiary of E. I. du Pont de Nemours & Co. (Inc.)

Kenilworth, New Jersey 07033

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What are the characteristics distinguishing the hard contact lens from the soft contact lens?

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Hard contact lenses are made of methacrylate or plexiglass, a material that provides excellent visual acuity in a wide range of visual defects. Since soft contact lenses weigh more than hard contact lenses, they have to be fitted slightly larger than the cornea diameter. They range in diameter from 12.3 to 15.5 mm. Hard lenses, in contrast, are presently fitted from 7.00 to 9.00 mm in diameter and don't quite cover the cornea. Due to the fact that these lenses are fitted larger than the cornea, one of the major problems of hard lens wearers—dirt specks or particles lodging under the lens—seldom arises with soft lenses.

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Continued on page 14



## wine talk

By JOHN CHAMBERS  
Author and Consultant to  
Morrell & Company,  
New York Wine Merchants

### Wine Books

A few days ago I was lunching with a friend and an out-of-town colleague who was visiting him. Hearing that the colleague was a doctor, I asked whether he had ever read this column. He said he had, and when I asked for his comments, he mentioned several things pro and con. "There's only one thing you haven't done that I wish you would," he added. "Do a column on wine books."

Wine books can be divided into four categories: the general guides, the encyclopedias, the detailed books on specific areas, and the so-called cocktail table books which range from pictorial tours of the world's vineyard areas to pleasantly chatty discussions of wine and the wine life.

Of the general guides, the best is probably the *Signet Book of Wine* (Signet paperback) by Alexis Bespaloff. This is a 221-page volume which passes the wines of the world through a quick but cogent review, and then considers the matters of serving, storing, ordering in restaurants, etc. Other good inexpensive books of this type are the *Vintage Wine Book* by William Leedom (Vintage), and *An Insider's Guide to Low-priced Wines* by William Massee (Dolphin). In hardcover, *Wine* by Hugh Johnson (Simon & Schuster) is top-rate, and I would recommend (if it can be found) *Wines* by Julian Street (Knopf), an old classic.

### Major Encyclopedias

The first of the major encyclopedias to appear on the market was produced under the direction of Frank Schoonmaker (*Encyclopedia of Wine*, Hastings House). It is an excellent book with an emphasis on precision and conciseness. Somewhat broader in scope and more designed for general readability is the *Encyclopedia of Wine and Spirits* by Alexis Lichine (Knopf). Recently Hugh Johnson has authored a *World Atlas of Wine* (Simon & Schuster) which combines detailed maps and an informative text. It is a rare avist.

The best way to approach the third category is by region. Fortunately a few books have surfaced as best-in-class, and these will give the reader as much detailed information as he will ever need. My recommendations would be: *The Wines of France* (Lichine, Knopf), *The Wines of Germany* (Schoonmaker, Hastings House), *The Wines of Italy* (Ray, McGraw-Hill), *The Great Wines of Italy* (Dallas, Doubleday), *Sherry and the Wines of Spain* (Rainbird, McGraw-Hill), *The Wines of Portugal* (Allen, McGraw-Hill), *The Wines of America* (Adams), *The Treasury of American Wines* (Chroman, Crown), and *The Wines, Vineyards, and Vignerons of Australia* (Simon, Lansdowne Press).

The fourth category is a buy-what-attracts-you area. I would recommend particularly the wine diaries of Harry Waugh. They provide excellent reading.

## Diurnal Excretion May Sift Renal from Essential Hypertension

Medical Tribune World Service

MARTIN, CZECHOSLOVAKIA—Essential hypertension may be distinguished from hypertension due to renal artery stenosis on the basis of diurnal rhythm of sodium and water excretion, according to Drs. Ota Schuck and Jarmila Strbina, of the clinical pharmacology unit, Institute of Clinical and Experimental Medicine, Prague.

Both groups of patients show nocturia, the investigators reported at a meeting of the International Endocrine Society here. However, a large study has established that patients with essential hypertension excrete sodium and water at the same rate during day and night (day/night ratio of 1.0), while those with renal hypertension excrete more

Na and water at night (day/night ratio less than 1.0). The normal ratio of day to night sodium excretion is about 1.5.

The characteristic diurnal rhythm excretion patterns remained even after treatment with reserpine, hydralazine, or other antihypertensive agents brought blood pressure down, the researchers said. Neither are diurnal rhythms affected by salt intake. Furthermore, there was no statistical relationship between levels of Na excretion, mean blood pressure, or creatinine clearance.

The data suggest that control of nocturia is at the level of tubular transport in the kidneys and unrelated to renal hemodynamics, the investigators said. They speculated that at some stage in the development of essential and

renal hypertension a resetting of tubular transport occurs that is resistant to change, even after blood pressure is reduced.



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## The familiar refrain of depression: morning fatigue... sadness... anorexia... insomnia

Now, Merrell offers Norpramin (desipramine hydrochloride tablets N.F.) to effectively relieve these common manifestations of depression.

Norpramin also provides additional benefits in treatment of your patients.

- ☐ effectively relieves physical, psychological and emotional symptoms of depression
- ☐ relief that may begin in 2 to 5 days—but full therapeutic effect is seldom seen before 2 weeks
- ☐ minimal daytime sedation—important for patients who must be alert to perform daytime activities
- ☐ side effects rarely require discontinuation of therapy

Prescribe Norpramin to change the familiar refrain of depression in your practice.

### Norpramin®

(desipramine hydrochloride tablets N.F.)

**Brief Summary:** Norpramin (desipramine hydrochloride tablets N.F.) is indicated for the relief of depressive symptoms. Endogenous depressions are more likely to be alleviated than others. **Contraindications:** Desipramine hydrochloride should not be given within two weeks of treatment with a monoamine oxidase inhibitor. Contraindications include the acute recovery period following myocardial infarction and hypersensitivity to the drug. **Warnings:** (a) Extra caution should be used in patients with cardiac disease, (b) with a history of seizure disorder, (c) with a history of alcoholism, (d) with a history of drug abuse, (e) with a history of glaucoma, (f) with a history of urinary retention, (g) with a history of hypotension, (h) with a history of heart disease, (i) with a history of liver disease, (j) with a history of kidney disease, (k) with a history of diabetes, (l) with a history of thyroid disease, (m) with a history of epilepsy, (n) with a history of asthma, (o) with a history of hypertension, (p) with a history of hypotension, (q) with a history of hyperkalemia, (r) with a history of hypokalemia, (s) with a history of hyponatremia, (t) with a history of hypernatremia, (u) with a history of hypocalcemia, (v) with a history of hypercalcemia, (w) with a history of hypomagnesemia, (x) with a 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# "Let me tell you about the medicine I'm going to prescribe."

## TALKING OVER VALIUM®(diazepam) THERAPY WITH YOUR ANXIOUS PATIENT



A patient often benefits by a greater understanding of his treatment program. You may find it helpful to make your patient aware that the purpose of therapy with Valium is to help reduce discomforting and disabling symptoms of excessive psychic tension and anxiety. It is beneficial for him to understand that much of his tension and anxiety can be relieved by your reassurance and counseling, and that these measures can do more than anything else to help him cope with his basic problems. The patient is reassured in knowing he can expect his medication to help him avoid feeling overwhelmed by his symptoms.

And it's also good for him to realize that he will be taking Valium only as long as he needs it.

Your expressed confidence in the medication prescribed, and the positive atmosphere in which therapy is given and accepted, work to the patient's advantage.

Selection of a dosage regimen is an important consideration when Valium (diazepam) is prescribed, and dosage should be individualized to achieve maximum beneficial effect. If the patient understands clearly when and how much to take, and if he knows why it's to his benefit to follow the regimen closely, the chances are better that he will take the medication precisely as directed. That should help avoid missed doses and discourage taking too much or too little medication — all of which can have an undesirable effect on the management of the patient's condition.

*"It's important that you  
follow my directions  
closely."*

*"I'll see you again the week  
after next and we'll see  
how you're making out."*

Your patient is often likely to feel reassured when you talk about seeing him again to check his progress. A planned visit evidences your continued interest and affords the patient an opportunity to report improvement he has made and to relate whatever continuing or additional difficulties he may be experiencing. It's also a chance for him to describe his response to therapy with Valium.

During follow-up visits, as your patient talks about his medication and about its effects on his symptoms, he will provide the kind of information that will be of great help in evaluating total therapy, adjusting the dosage of Valium, or discontinuing the medication entirely if that seems indicated.

# Valium®(diazepam)

2-mg, 5-mg, 10-mg scored tablets  
for individualized treatment of psychic tension



Please see the following page for a summary of product information.



# Valium® (diazepam)

2-mg, 5-mg, 10-mg scored tablets

Prompt, effective action. Valium (diazepam) works rapidly to relieve pronounced psychic tension in patients overreacting to stress and in psychoneurotic patients.

Before prescribing, please consult complete product information, a summary of which follows:

**Indications:** Tension and anxiety states; somatic complaints which are concomitants of emotional factors; psychoneurotic states manifested by tension, anxiety, apprehension, fatigue, depressive symptoms or agitation; symptomatic relief of acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal; adjunctively in skeletal muscle spasm due to reflex spasm to local pathology; spasticity caused by upper motor neuron disorders; athetosis; stiff-man syndrome; convulsive disorders (not for sole therapy).

**Contraindicated:** Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma; may be used in patients with open angle glaucoma who are receiving appropriate therapy.

**Warnings:** Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms (similar to those with barbiturates and alcohol) have occurred following abrupt discontinuance (convulsions, tremor, abdominal and muscle cramps, vomiting and sweating). Keep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence. In pregnancy, lactation or women of childbearing age, weigh potential benefit against possible hazard.

**Precautions:** If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed; drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other anti-

depressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

**Dosage flexibility.** Scored Valium 2-, 5-, and 10-mg tablets give you dosage flexibility no tranquilizer capsule can match.

**Side Effects:** Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.

**Dosage:** Individualize for maximum beneficial effect. **Adults:** Tension, anxiety and psychoneurotic states, 2 to 10 mg b.i.d. to q.i.d.; alcoholism, 10 mg t.i.d. or q.i.d. in first 24 hours, then 5 mg t.i.d. or q.i.d. as needed; adjunctively in skeletal muscle spasm, 2 to 10 mg t.i.d. or q.i.d.; adjunctively in convulsive disorders, 2 to 10 mg b.i.d. to q.i.d. **Geriatric or debilitated patients:** 2 to 2½ mg, 1 or 2 times daily initially, increasing as needed and tolerated. (See Precautions.) **Children:** 1 to 2½ mg t.i.d. or q.i.d. initially, increasing as needed and tolerated (not for use under 6 months).

**Supplied:** Valium® (diazepam) Tablets, 2 mg, 5 mg and 10 mg—bottles of 100 and 500; Tel-E-Dose® packages of 100, available in trays of 4 reverse-numbered boxes of 25, and in boxes containing 10 strips of 10; Prescription Paks of 50, available singly and in trays of 10.



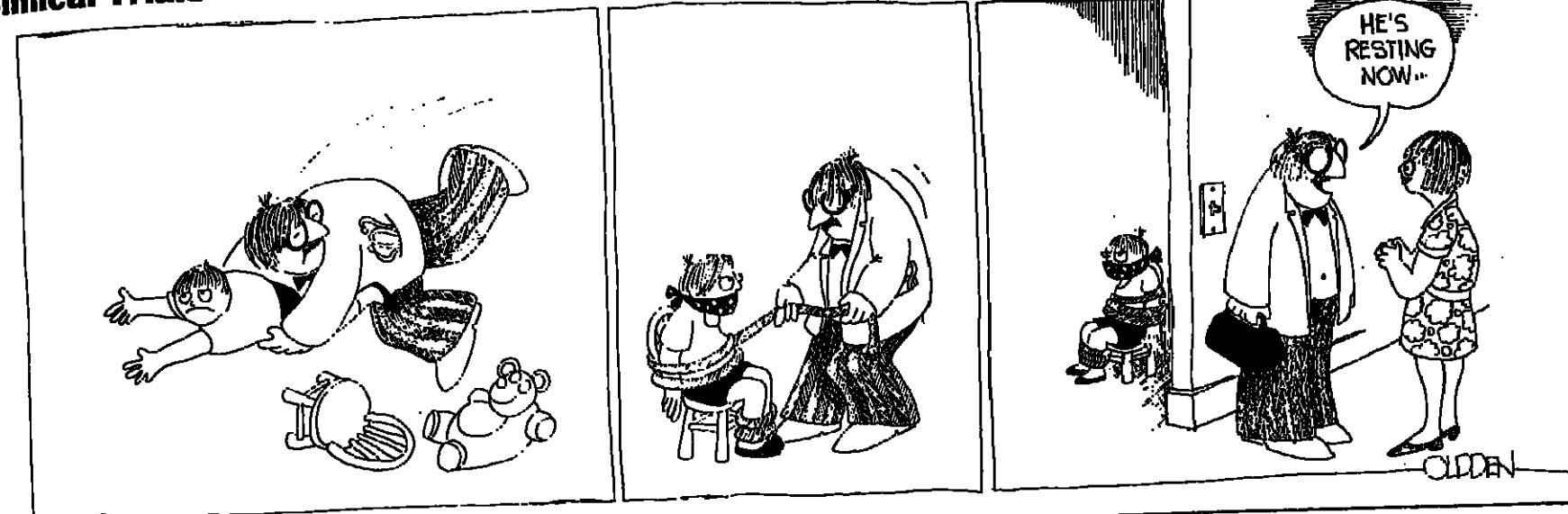
Roche Laboratories  
Division of Hoffmann-La Roche Inc.  
Nutley, New Jersey 07110

Wednesday, November 5, 1975

MEDICAL TRIBUNE

19

## Clinical Trials



## New Combined Drug Held Effective Against All Bacteria Tested

Continued from page 2  
bactericidal activity. In fact, the researchers reported, PCS not only eliminates DFA self-reversal but also enhances the antimicrobial activity of both agents manifold.

The new drug has proven equally effective when given to mice orally or by injection against a broad spectrum of bacterial species, including all the serious pathogens for man. The Merck scientists were particularly pleased that *Pseudomonas aeruginosa*, a highly resistant pathogen which is a growing problem in hospitalized patients, proved susceptible to the drug's effect.

According to Dr. Christopher M. Martin, senior director of medical affairs at Merck's research laboratories, not one bacterial strain tested so far has been resistant to the drug. He said the company was "cautiously optimistic that bacteria will have a terrible time with this drug."

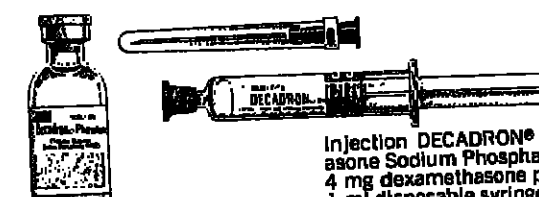
Apprehension that the new agent might kill off harmless and necessary bacteria as well as virulent pathogens has been dispelled by studies in mice which show that it is absorbed into the bloodstream from the upper intestinal tract, Dr. Martin said. Bacteria in the lower tract, the mouth and the skin were unaffected.

Safety testing in human volunteers is expected to begin in early 1976, Dr. Martin announced. Monkeys receiving up to 30 times the normal human dose have exhibited no side effects. However, he cautioned, earlier cycloserine drugs also produced no side effects in animals but caused tremors, behavioral changes and convulsions in humans.

## Outpatient Arteriography

**Medical Tribune Report**  
ROCKLAND, MAINE—Outpatient arteriography could mean considerable savings in hospital fees, Drs. Peter E. Giustra and Paul J. Killoran, of the radiology department of Knox County General Hospital, said recently. In a four-year study of 300 patients requiring arteriography, the physicians found no increase in complications and no hospital readmissions among 100 outpatients. The study confirms other reports that complications arise during or right after arteriography.

## INJECTABLE



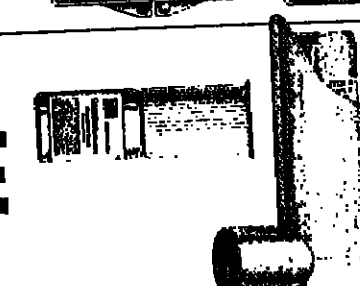
Injection DECADRON® Phosphate (Dexamethasone Sodium Phosphate) (MSD) equivalent to 4 mg dexamethasone phosphate per ml, in 1-ml disposable syringes and 1-ml, 5-ml, and 25-ml vials.

## INGESTIBLE



Tablets DECADRON® (Dexamethasone) (MSD) 0.75 mg, in bottles of 100 and 5-12 PAK® (package of 12).

## BREATHABLE



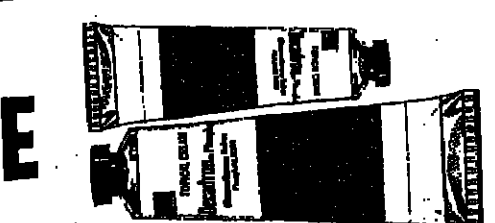
RESPIHALER® Phosphate (Dexamethasone Sodium Phosphate) (MSD) containing per metered spray: dexamethasone sodium phosphate equivalent to approximately 0.1 mg dexamethasone phosphate or 0.084 mg dexamethasone, fluorochlorohydrocarbons as propellants, and alcohol 2%, in 12.5-g cartridge delivering at least 170 sprays and refill cartridge.

## DROPPABLE



Sterile Ophthalmic Solution DECADRON® Phosphate (Dexamethasone Sodium Phosphate) (MSD) 0.1% equivalent to 1 mg dexamethasone phosphate per ml, in 5-ml COLLIMETER OPTHALMIC DISPENSER and 2.5-ml and 5-ml dropper bottles.

## SPREADABLE



Topical Cream DECADRON® Phosphate (Dexamethasone Sodium Phosphate) (MSD) 0.1% equivalent to 1 mg dexamethasone phosphate per gram, in 15-g and 30-g tubes.

## SPRAYABLE



Topical Aerosol DECASPRAY® (Dexamethasone) (MSD) 10 mg per 90-g container, TURBINAIR® DECADRON® Phosphate (Dexamethasone Sodium Phosphate) (MSD) equivalent to approximately 0.1 mg dexamethasone phosphate or 0.084 mg dexamethasone per metered spray, in 12.5-g cartridge delivering 170 sprays.

## DECADRON® (DEXAMETHASONE) (MSD)

Now Suspension DECADRON-LA® (DEXAMETHASONE ACETATE) (MSD) equivalent to 8 mg dexamethasone per ml, in 5-ml vials.



## Major Victory Seen in Grant Policy Reversal

Continued from page 1

O.M.B., ever the dour keeper of the government's purse strings, had vigorously opposed continuation of the main education-funding feature of the 1971-74 law—capitation, under which health schools have been granted specified amounts of money for each student they enroll.

Dr. Mathews, who, as president of the University of Alabama, had worked hand-in-hand with the university's College of Community Health Sciences to resolve health manpower problems in rural Alabama, presumably brought his experience to bear in convincing the White House Domestic Council to endorse the new approach. Dr. Cooper, for his part, was also reportedly dissatisfied with the old line of thinking.

The anticipated legislation, which would replace the 1971-74 health manpower law that expired at the middle of last year, specifies among other things how and to what extent the federal government will finance the training of physicians, osteopaths, dentists, veterinarians, optometrists, pharmacists, podiatrists, and public health specialists.

### 'Imaginative' and 'Responsive'

Although the first bill to replace the expired statute was introduced a year and a half ago and many others have been put forward since then, no new law has been enacted because of conflicts over ways to support health education, spending levels, and methods of dealing with geographic and specialty maldistribution and the foreign medical graduate (FMG) problem.

Unexpectedly, on September 16 Dr. Cooper outlined a completely new administration proposal.

Senator Kennedy, who with other legislators (including Republicans) had been dismayed by what they called the negativity of previous administration bills, immediately hailed Dr. Cooper's testimony before his Senate health sub-

## High Cataract Rate Found In Asthmatic Children On Corticosteroid Drugs

Continued from page 1

"Findings in the children we looked at, when compared to our control of 35 child asthmatics who had not been on oral steroids, are definitely cause for concern," he added.

Although most of the children studied had been taking prednisone, the investigators said they could not incriminate one steroid over another. And despite earlier reports of the possibility that the presence of eczema might have a relationship in cataract formation in patients who are on chronic steroid treatment, the study found no such evidence.

"Clearly, our point is that there may be some children who don't need the doses now being prescribed, and maybe in the future we should look more carefully at the efficacy of day to day steroid therapy," Dr. Spaulding said.

"At any rate," he added, "there is no doubt that children who require corticosteroids to keep their asthma under control should be afforded the opportunity of ophthalmologic examination at least once a year."

committee as "enormously forthcoming," "imaginative," and "responsive."

So effusive were the Senator and Assistant Secretary in their expressed mutual admiration that a subcommittee staff member afterwards called the session "a regular love feast."

Earlier administration bills would have drastically reduced capitation payments as a prelude to abolishing them, but the Senate and House bills that passed their respective chambers last year, but never reached conference, and the refurbished bill that the House passed on July 11 all continued capitation as a basic policy. Now so does the Cooper proposal for schools of medicine, osteopathy, and dentistry, though it reduces capitation payments for student veterinarians, optometrists, and podiatrists and abolishes them for fledgling pharmacists.

H.E.W.'s showdown with O.M.B. and the White House's decision to throw administration support behind capitation occurred only hours before Dr. Cooper was scheduled to testify at the opening session of the Kennedy subcommittee's 1975 hearings on health manpower legislation.

The cliff-hanging nature of the struggle within the administration was such, according to H.E.W. sources, that two prepared testimony statements were actually written for the Assistant Secretary—one favoring capitation and the other opposing it. Some senior H.E.W. officials did not learn which testimony he would present until an hour before he began speaking.

The new administration proposal, which has not yet been formally introduced in either house, would continue capitation at the current level of \$1,500 per year for medical, osteopathic, and dental students, phase it out over the three years of the new law's life (fiscal years 1977 through 1979 if it is enacted by the middle of next year) for veterinary, optometric, and podiatry students, and discontinue it at once for pharmacy students.

It also deals in a much more concrete way than previous administration proposals with the maldistribution and FMG problems that have received so much attention in legislators' bills.

### \$55 Million in Scholarships

To remedy the geographic maldistribution of health workers—and particularly doctors—the proposal would require schools to set aside percentages of their enrollments for students who agree to practice in underserved areas after graduation (15 percent in fiscal 1977, 20 percent in fiscal 1978, and 25 percent in fiscal 1979). It would also establish a scholarship program for such students amounting to \$55 million for 5,000 students in fiscal 1977, \$75 million for 7,500 students in fiscal 1978, and \$95 million for 9,500 students in fiscal 1979. Capitation payments to medical, osteopathic, and dental schools that did not agree with these plans would be phased out over the law's life.

To encourage the production of more primary care physicians (general and family practitioners, general internists, obstetrician-gynecologists, and pediatricians), medical schools would have

to maintain a specified percentage of their residencies in those specialties (35 per cent in 1977, 40 per cent in 1978, and 50 per cent in 1979).

Though other bills have provisions written into them that would limit the number of FMG's allowed into American residency programs, generally to 25 per cent more than the previous year's total of new graduates from domestic medical schools, the new administration proposal is less specific.

### Single Qualifying Exam

"The department...supports the development of a single qualifying examination for all physicians who are entering hospital training programs where they will have some responsibility for patient care," Dr. Cooper said. "We propose to convene appropriate organizations and groups for the development of such an examination. Because this examination is not yet established and because immigrant physicians should be expected to meet standards of U.S. medical graduates in provision of care in the United States, it is proposed that the department will determine the most appropriate screening examination for FMG's."

He also suggested that H.E.W. should develop ways to integrate Americans studying medicine abroad into U.S. medicine through transfer programs.

The new administration measure still differs in some respects from Senator Kennedy's own and that passed by the House in July.

Because the administration, Ken-

## New Procedure Corrects Transposed Great Arteries

Continued from page 1

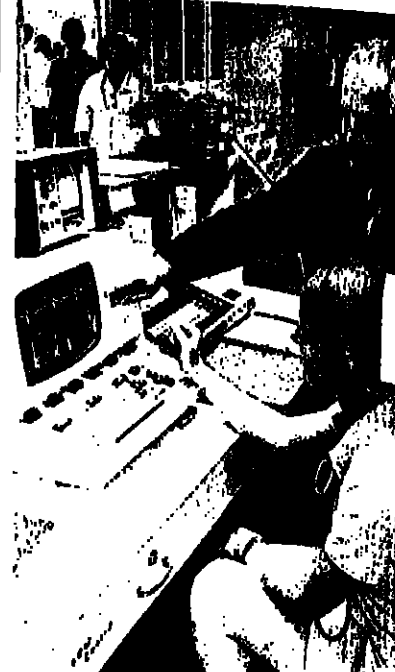
Jatene stressed that efforts to accomplish total arterial correction of transposed vessels go back to 1954 and 1955 when Drs. Charles C. Bailey and E. B. Kay independently sought to achieve anatomical correction of the defect. Later ingenious attempts to make the correction on the arterial side have been clinical failures, and more recent ideas have not progressed beyond the experimental level, Dr. Jatene noted. In the standard Mustard procedure, the right coronary remains in the pulmonary artery.

The twin keys to the new technique, according to Dr. Jatene, are (1) to excise both coronaries, along with a piece of the aortic wall—prior to implanting in the pulmonary artery—in order to ease suture problems and avoid later stenosis; and (2) to transect the great vessels far from the valves, so that the anastomoses are easier to do and to correct if leaks are observed.

The technique emerged in the course of extensive experience with aortic-coronary bypass surgery, Dr. Jatene said, adding: "We believe it is reproducible by most cardiovascular surgeons."

Briefly, in Dr. Jatene's procedure, the ascending aorta and pulmonary trunk are dissected out. The two coronaries, along with a piece of the aortic wall, are resected and implanted in the pulmonary artery, still in the posterior

## Computer Monitors Heart



Use of new computer-assisted arrhythmia monitor (American Optical) is demonstrated by Dr. Edward A. Partenope and Monica Gelger, R.N., at JFK Medical Center, Edison, N.J.

nedy, and other proposals have still to work their way through the Senate's health subcommittee, the full Labor and Public Welfare Committee, and the Senate itself, it is not considered likely that the Senate will vote out a bill until next spring. When it does, its version of the legislation will have to be reconciled with the House's in conference committee before it goes to the President for signature.

position. The openings in the aortic wall are closed with a patch. The aorta and pulmonary artery are transected, transposed and then anastomosed. The differences in diameter between the two vessels are equalized by two sutures in the distal and proximal ends of the pulmonary artery so that they correspond to the diameter of the ends of the aorta. The ventricular septal defect is then closed through a right ventriculotomy with a patch.

### In Good Condition

In the first clinical trial, the Jatene procedure was performed in an infant with transposed vessels and a large VSD. Hemodynamic studies 20 days after surgery showed complete correction of the defect. The postoperative course was uneventful and the infant at seven months followup is in good condition without cyanosis, Dr. Jatene reported.

Collaborators were Drs. V. G. Fontes, P. P. Paulista, L. C. B. de Souza, F. Neger, M. Galantier and J. E. M. R. Souza.

In an interview, Dr. Kirklin commented that while there "will be no stampede to use the Jatene technique, it will unquestionably be tried all over the world. Cardiovascular surgeons have been interested for a long time in achieving a correction of this anomaly on the arterial side."

## One Man...and Medicine

ARTHUR M. SACKLER, M.D.,  
International Publisher, Medical Tribune



## To Direct and Not Distract Public Interest Part II

DO NOT THE CONSUMER and so-called "public interest" advocates recognize that unbalanced attacks against doctors and drugs are as dangerous a form of misrepresentation as misleading advertising?

Are they not bound by a higher ethic than that which they feel should apply to the puffery of the propaganda and the actions of vested interests? If the public interest groups represent the interests of the public, should they not lead rather than mislead, should they not direct and not distract?

### They cannot have it both ways.

What are the truly major preventable causes of morbidity and mortality in the United States today? Doctors and drugs? The less developed nations of the world do not think so as they suffer the ravages of diseases which are now so rare here they can hardly be demonstrated to medical students in this country.

One would think that implicit in the conclusions of a public interest group calling for cessation of new hospital construction should be the recognition that in an ever-increasingly polluted environment something has happened to reduce morbidity and diminish the need for hospital facilities. Could it be, heaven forbid, doctors and drugs?

### They can't have it both ways.

### Dangerous Distortions

Why are alcohol and tobacco so conspicuous by their absence from the activities of most of the "public interest" groups? As serious a problem as street drugs were, the drug hysteria of the preceding area distracted the public from real issues. We know that in this less than "best of all possible worlds" some doctors and drugs are deficient; that does not justify a rejection of modern medicines. To do so is to distort reality.

It is dangerous to the public and its health to focus on minor issues while simultaneously shifting attention away from major problems. It is dishonest to contribute, in any way, to obfuscating the enormous preventable morbidity and mortality victimizing Americans. Such distortions of health perspectives raise serious questions as to the intent and the integrity, the intelligence and influence of certain individuals who could exert positive rather

### EPIGRAMS—Clinical and Otherwise

Only the lion and the cock, as Galen says, withstand love's shock. So dearest, do not think me rude if I now yield to lassitude but sympathize with me. I know you would not have me roar, or crow.

Oliver St. John Gogarty, M.D.  
(1878-1957)  
in *After Galen*

## Medicine on Stamps

Joseph Warren



US Bicentennial 10c

Born in Roxbury, Mass., in 1741, he graduated from Harvard in 1759, studied medicine, and very quickly became one of the leading medical men in Boston. Passage of the Stamp Act aroused his patriotic sympathies and he worked diligently in the cause of liberty. Commissioned a major general, he was killed in the battle of Bunker Hill in 1775. He is pictured as the dying soldier in the painting reproduced on the stamp above.

Text: Dr. Joseph Kler  
Stamp: Minkus Publications, Inc., New York

## 'PERC' Bag Aids Prevention Of Postoperative Atelectasis

Medical Tribune Report

SAN FRANCISCO—An effective, inexpensive device which has proved highly reliable in the prevention of postoperative atelectasis has been developed here by a University of California pulmonologist.

Called a perioperative respiratory care (PERC) bag, the device developed by Dr. Anthony Cosentino, director of the pulmonary laboratories at St. Mary's and Mt. Zion Hospitals, and Associate Clinical Professor of Medicine at the University of California, fills the "need for a device which allows physicians to calibrate the breaths a postoperative patient takes in efforts to prevent pulmonary complications and gauge necessary amounts of pain medication," Dr. Cosentino told MEDICAL TRIBUNE.

The new device consists of a condom enclosed by a one, one-and-a-half, two or three liter polyethylene bag, which is vented to insure against significant back pressure, making it effortless for a patient to fill.

According to Dr. Cosentino, the device—which sells to hospitals for about \$2 each—has successfully helped prevent postoperative atelectasis in about 100 patients, without the use of an intermittent positive pressure breathing (IPPB) device.

### Patient Does the Work

"We needed an inexpensive bedside device that the patient could operate, and at the same time give us inspiration volume and a good index for amounts of pain medication to administer," Dr. Cosentino said.

Although the patient does all the work, he added, technically the PERC bag is a positive pressure device that works as well as the conventional IPPB.

"This is in essence a positive pressure device, because even the normal breath a person takes is done so under positive atmospheric pressure. Pressure at the mouth is 1,000 centimeters of water, so as the thorax is expanded, thoracic pressure drops to something sub-atmospheric—hence, there exists a

positive pressure from the mouth into the lungs. This is where there is a gross misunderstanding in thinking IPPB is something magic just because the pressure is a little superatmospheric," he explained.

Elaborating on what he calls "the overated IPPB," Dr. Cosentino remarked that cost of the new device, coupled with its proven effectiveness in helping to prevent atelectasis and ability to gauge breath volume, make it more practical than IPPB, blow gloves or other conventional equipment.

One problem, he added, is that too many doctors believe positive pressure is superior to breathing and lose sight of the fact that the act of breathing alone is positive pressure.

"A lot of physicians expound the wonders of IPPB, but the simple fact is that most authorities in the field agree the inspiratory maneuver is the 'important thing,' he said.

## Hypothermia of Brain Only Preferred in Hypoxia Risk

Medical Tribune World Service

PRAGUE, CZECHOSLOVAKIA—Local hypothermia of the brain is preferable to whole body hypothermia in surgery and trauma where brain function is endangered by hypoxia, Dr. V. A. Bukov, of the Laboratory for Tissue Transplantation, Academy of Medical Sciences, Moscow, told the International Congress of Pathological Physiology here.

The craniocerebral cooling technique has been used clinically in over 1,000 cases of open heart surgery, with heart stoppages up to 30 minutes, and in neurosurgery as well, Dr. Bukov said. Future work will try to extend the time limit even further.

The technique utilizes a new apparatus which by cooling the surface of the cranium can automatically attain and keep brain temperatures at preselected levels (e.g., 26°C) while moderately cooling the rest of the body to another level (e.g., 30 or 31°C). The apparatus also permits rapid return of temperatures to normal when desired.

## Implanted 'Umbrella' Filter Prevents Recurrent Emboli

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Although the procedure is simple, it is associated with some possible risks and complications, Dr. Schlosser noted. These include errors in placing the filter, shifting of the screen, recurrence of embolism (rarely), and especially edema of the lower extremity.

Dr. Schlosser said patients were generally given constant anticoagulant therapy for one to two years after the operation. To evaluate the hemodynamic situation, 25 patients were examined by cavography over a period of six months to two years.

In eight, the team found complete blocking of the v. cava in the area of the screen filter, with the formation of excessive collaterals, and some tendency to edema of the lower extremity.

"However, four of those had a pelvic and leg vein thrombosis before the operation, with a tendency to edema."

Another eight showed partial blocking with beginning collaterals, without edema of the lower extremity, and nine patients showed a completely patent filter without collateralization or tendency to edema.

"Summing it up, the method offers a high measure of protection against pulmonary embolism, with a degree of risk that is tolerable," said Dr. Schlosser.

In certain cases, it could be used prophylactically in phlebographical confirmed, fresh pelvic and leg vein thromboses, especially in the lower legs, with freely floating thrombi the pre-op and post-op phases.

## IN CONSULTATION

Continued from page 13

enced by their inability to switch back to eye glasses. Changes induced in the cornea by hard lens wear may make the acuity through eye glasses changeable and unsatisfactory for long periods of time after the hard lenses are removed. Experience has shown that complications such as spectacle blur or abrasion occur much less frequently with soft than with hard contact lenses.

Certainly, soft contact lenses are less durable than hard lenses. However, since soft lenses cling to the eye better than the hard ones, they are much less likely to fall out accidentally, not a rare occurrence with hard lenses. Statistics have reported between 25 and 40 per cent of hard contact lens wearers lose one or both of their lenses within the first six months. Of even greater importance is the fact that most of the instances of corneal abrasion, irritation or spectacle blur are produced by a warped, scratched, old, hard contact lens. Both hard and soft contact lenses should be replaced periodically to let the lens wearer benefit from new materials or improvements in technology, and to avoid the damage that can be caused by warped or scratched hard lenses or old soft lenses that have become coated with mucous. It is better not to save the patient's money than to risk potential damage to the eye.

The heat sterilization method employed by one manufacturer of soft lenses and the cold, hydrogen peroxide sterilization procedure employed by another are both extremely safe and effective, with an incidence of clinical bacterial infection certainly not greater than that found in hard contact lenses and perhaps approaching that found in individuals wearing spectacles.

Is there any advantage or disadvantage in having both spectacles and contact lenses?

Eye glasses are the safest, most effective device for the correction of refractive errors. Every contact lens patient should have a pair of spectacles that provide best visual acuity so as to enable free alternation with contact lenses. In addition, when the wearer of hard lenses does put on regular eye glasses and is unable to see clearly, this may be an indication of spectacle blur requiring attention.

A contact lens wearer should be able to switch to eye glasses as necessary for correction and/or comfort, elimination of glare or difficulty seeing at night, or when there are problems of visual acuity, conjunctivitis, irritation, or other complications.

### Next in Consultation

DR. JAMES M. STENGLE, Deputy Director for Medical Affairs, Lister Hill National Center for Biomedical Communications, N.J.H., and Chairman, Medical and Scientific Advisory Council, National Hemophilia Foundation, will discuss what's new and important in hemophilia.

## SLEEPING BETTER...

## THE BEGINNING OF THE END OF CLINICAL DEPRESSION/ANXIETY

Even before it helps her clinical depression/anxiety, Sinequan (doxepin HCl) can help her sleep through the night.

The sedative effect of Sinequan usually helps clinically depressed/anxious patients with accompanying sleep disturbances fall asleep more easily, remain asleep, and awaken more rested.

Administering the major portion of the daily dose h.s. generally obviates the use of supplementary hypnotic agents.

The marked anti-anxiety property of Sinequan is particularly helpful in relieving apprehension, tension and worry. Optimal antidepressant effect is usually seen two to three weeks after initiation of therapy.

# SINEQUAN<sup>®</sup>

## DOXEPIN HCl

10 mg., 25 mg., 50 mg. and new 150 mg. Capsules

### BRIEF SUMMARY

Sinequan<sup>®</sup> (doxepin HCl) Capsules

**Contraindications:** Sinequan is contraindicated in individuals who have shown hypersensitivity to the drug.

Sinequan is contraindicated in patients with glaucoma or a tendency to urinary retention.

**Warnings:** Usage in Pregnancy: Sinequan has not been studied in the pregnant patient. It should not be used in pregnant women unless, in the judgment of the physician, it is essential for the welfare of the patient, although animal reproductive studies have not resulted in any teratogenic effects.

**Usage in Children:** The use of Sinequan in children under 12 years of age is not recommended, because safe conditions for its use have not been established.

**MAO Inhibitors:** Serious side effects and even death have been reported following the concomitant use of certain drugs with MAO inhibitors. Therefore, MAO inhibitors should be discontinued at least two weeks prior to Sinequan (doxepin HCl). The exact length of time may vary and is dependent upon the particular MAO inhibitor being used, the length of time it has been administered, and the dosage involved.

**Precautions:** Since drowsiness may occur with the use of this drug, patients should be warned of that possibility and cautioned against driving a car or operating dangerous machinery while taking this drug.

Patients should also be cautioned that their response to alcohol may be potentiated. Since suicide is an inherent risk in any depressed patient and may remain so until

significant improvement has occurred, patients should be closely supervised during the early course of therapy.

Although Sinequan (doxepin HCl) has significant tranquilizing activity, the possibility of activation of psychotic symptoms should be kept in mind.

Other structurally related psychotherapeutic agents (e.g., iminodibenzyls and dibenzocycloheptenes) are capable of blocking the effects of guanethidine and similarly acting compounds in both the animal and man. Sinequan, however, does not show this effect in animals. At the usual clinical dosage, 75 to 150 mg. per day, Sinequan can be given concomitantly with guanethidine and related compounds without blocking the antihypertensive effect. At doses of 300 mg. per day or above, Sinequan does exert a significant blocking effect. In addition,

Sinequan (doxepin HCl) was similar to the other structurally related psychotherapeutic agents as regards its ability to potentiate norepinephrine response in the animal. However, in the human this effect was not seen. This is in agreement with the low incidence of the side effect of tachycardia seen clinically.

**Adverse Reactions, Anticholinergic Effects:** Dry mouth, blurred vision, and constipation have been reported. They are usually mild, and often subside with continued therapy or reduction of dose.

**Central Nervous System Effects:** Drowsiness has been observed. This usually occurs early in the course of treatment, and tends to disappear as therapy is continued.

**Cardiovascular Effects:** Tachycardia and hypotension have been reported infrequently. Other infrequently reported side effects

include extrapyramidal symptoms, gastrointestinal reactions, secretory effects such as increased sweating, weakness, dizziness, fatigue, weight gain, edema, paresthesias, flushing, chills, tinnitus, photophobia, decreased libido, rash, and pruritus.

**Dosage:** For most patients with illness of mild to moderate severity, a starting dose of 25 mg. i.d. is recommended. Dosage may subsequently be increased or decreased at appropriate intervals and according to individual response. The usual optimum dose range is 75 mg./day to 150 mg./day.

In more severely ill patients an initial dose of 50 mg. i.d. may be required with subsequent gradual increase to 300 mg./day if necessary. Additional therapeutic effect is rarely to be obtained by exceeding a dose of 300 mg./day.

In patients with very mild symptomatology

or emotional symptoms accompanying organic diseases, lower doses may suffice. Some of these patients have been controlled on doses as low as 25-50 mg./day.

Although optimal antidepressant response may not be evident for two to three weeks, anxiolytic activity is rapidly apparent.

**Supply:** Sinequan (doxepin HCl) is available as capsules containing doxepin HCl equivalent to 10 mg., 25 mg., 50 mg., and 100 mg. of doxepin in bottles of 100, 1000, and unit-dose packages of 100 (10 x 10's).

More detailed professional information available on request.

**Pfizer LABORATORIES DIVISION**  
New York, N.Y. 10017

## IMMATERIA MEDICA

### For the President Who Has Nothing

It may be that the President of your favorite medical society, country or club has everything, but just in case you're looking for something, we call your attention to an ad in the Miscellaneous column of the *Wall Street Journal*, sandwiched in between a peat moss ad (200,000 yards) and one for antique hallmarked British silver flatware:

MISCELLANEOUS  
FORMER PRESIDENTIAL PRIVATE RAILWAY CAR AVAILABLE. Fully equipped, for short or long term lease. Inquiries to be made to Chesterleite, Ltd., 250 Madison Avenue, New York City, 10017. (212) 685-1655

The short-term lease idea looked mighty attractive.

### Tut-tutted Again

We've been tut-tutted again by Dr. Sam Nixon of Floresville, Texas, because we referred to *The Education of H\*Y\*M\*A\*N K\*A\*P\*L\*A\*N* rather than *H\*Y\*M\*A\*N*, which is the way Dr. Sam correctly remembers it.

Our trouble is that we affectionately remember Hyman as Hymie. What can we say? It won't be the first time that affection has led us to err.

But if we may, we'd like to send up a cheer for Leo Rosten who discovered Hymie, Bronx-born and bred, and so hard-up for a tiny bit of recognition that he decorated his name with asterisks. It was probably the most expressive use of typography since e.e. cummings read archy and mehitabel in Don Marquis' column. Lest this be considered an "inside" joke accessible only to aging physicians (over 50), we will explain that archy was a cockroach whose physical limitations made it impossible for him to use the typewriter shift key for capitals and punctuation. It was archy who, in archy's new deal, said:

there is bound to be a certain amount of trouble running any country if you are president the trouble happens to you but if you are a tyrant you can arrange things so that most of the trouble happens to other people

